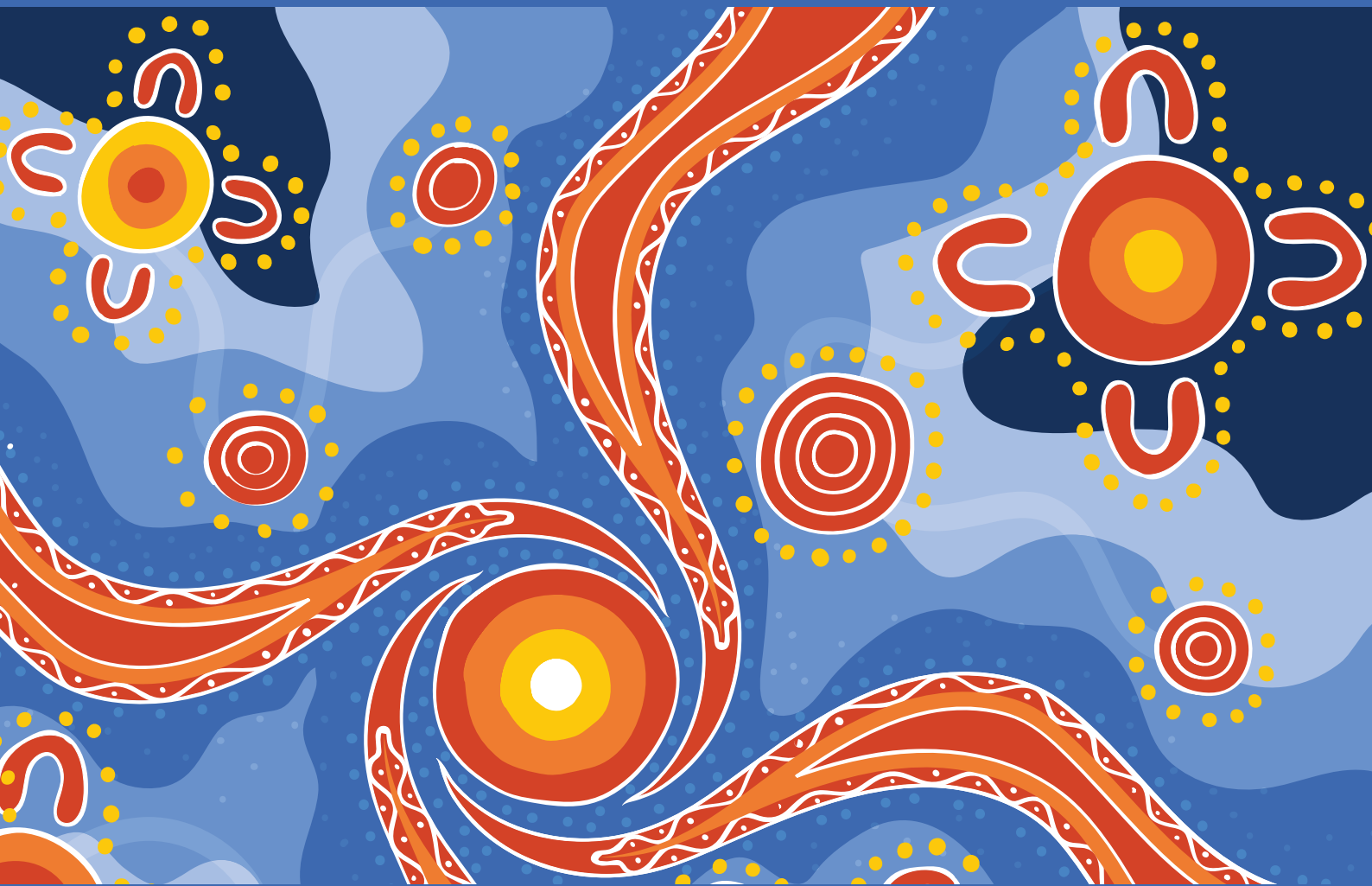




Aboriginal Health in South Australia 2011-2014: A Case Study

October 2014



Health Performance Council



Government
of South Australia

Health Performance Council

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Acknowledgements

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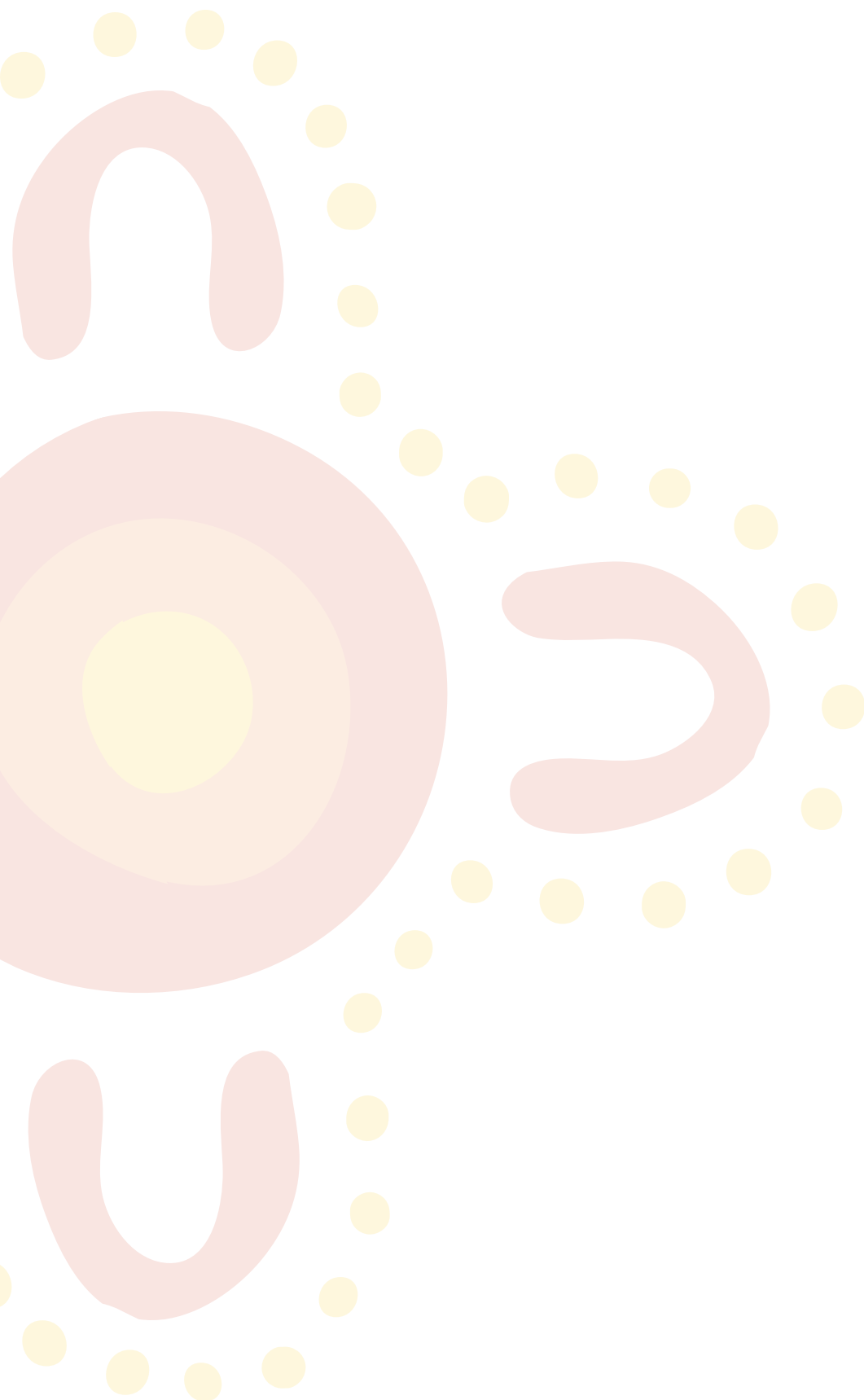
We also acknowledge the diversity of Aboriginal South Australians. The land on which South Australia sits is estimated to be the area of 50 different language groups at the time of European settlement and 36 continuing language groups.¹ Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite colonisation and dispossession.

The health and wellness of Aboriginal and Torres Strait Islander Australians are a significant concern for all Australian governments.² The Health Performance Council is aware of the complexities of the health system's engagement with Aboriginal South Australians and the social, environmental and economic factors that affect Aboriginal health. We have identified Aboriginal health as a priority reporting area.

The health and wellbeing of Aboriginal and Torres Strait Islander Australians are improved by respect of Aboriginal knowledges, histories, cultures, kinship relationships and community processes.^{3,4,5} Health services which provide culturally-appropriate treatment are able to successfully draw on the strength and endurance of Aboriginal Australians to support individuals to achieve wellness and communities to improve wellbeing. Culturally appropriate services not only improve client health, but are also a more efficient investment of health resources due to better returns in health outcomes.

You will note we use the term 'Aboriginal' in this document to refer to people who identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander. Some sources we cite use the general term 'Indigenous' to refer to Aboriginal and Torres Strait Islander people, but we do not. We do this because the people indigenous to South Australia are Aboriginal and we respect that many Aboriginal people prefer the term 'Aboriginal'.

We would like to thank Annetay Henderson-Sapir (principal author). This report also would not be possible without the comprehensive work of the Australian Bureau of Statistics, the Australian Institute of Health and Welfare and the South Australian Department for Health and Ageing. To these and other information sources listed throughout this document, we would like to express our thanks. We would also like to acknowledge the generous contribution of time and expertise by those who contributed to this project, in particular the Aboriginal Leaders' Working Group; see Appendix A.2 for a list of members.





Chapter 1: Findings and Advice

Finding: Some health service areas are succeeding in reducing the population health status differences between Aboriginal and non-Aboriginal people but the gap remains a significant challenge.

Advice:

1. SA Health to reduce any variations in health care outcomes between local health networks for Aboriginal people living in South Australia and aim for at least the national level for Aboriginal people by 2018.

Finding: Concerted system efforts are assisting many Aboriginal people to achieve health gains but significant numbers are still missing out.

Advice:

2. SA Health continue to provide culturally appropriate antenatal care by building on the successful Aboriginal Family Birthing Program to achieve antenatal care outcomes and meet existing targets for Aboriginal mothers and babies by 2018.
3. SA Health, through its local health networks, support the efforts of local governments, Medicare Locals or their successor, Aboriginal community-controlled services and public clinical services to lift the immunisation rate of Aboriginal children to at least 92% by 2018.

Finding: More Aboriginal people are accessing the right health care but the health system must do more to provide respectful, safe, relevant health services.

Advice:

4. SA Health to re-establish strategies to identify Aboriginal patients, like including identification methods in staff training, from July 2015.
5. The Chief Executive of SA Health holds local health networks accountable for the production of public, quality local implementation plans as soon as they can and no later than December 2014. The Local Health Network Aboriginal Health Care Plans to include:
 - a. Strategies to address the gap between Aboriginal people in South Australia and in other states who have chronic disease management plans with a target of meeting the national averages by July 2016.
 - b. Action and targets to fix the differences in rates of procedures in hospitals between Aboriginal and non-Aboriginal and metropolitan and rural and remote South Australians by July 2015.
 - c. Action to check rates of discharge against medical advice at each of their hospitals to find problems, and then work with Aboriginal leaders to find solutions. These solutions are to be put in place by July 2016 and their results monitored every six months after that.
 - d. Production of Aboriginal Health Impact Statements, the evaluation of their impact, and the publication of results as required under SA Health's 'Cultural Respect Framework'.
6. SA Health continue to lead the implementation and monitoring of culturally appropriate smoking cessation programs and achievement of smoking rates to meet the SA Government target of 16.5% by 2018.

7. SA Health to make sure all the steps recommended in the 'Summary Report: Statewide Aboriginal Mental Health Consultation July 2010' are put in place by July 2016.
8. SA Health work with the relevant services to meet the community follow-up after psychiatric discharge COAG 'National Action Plan on Mental Health' target of 75% by July 2016.

Finding: Aboriginal people are underrepresented in the health sector workforce and this needs to be addressed as a matter of urgency.

Advice:

9. The Chief Executive of SA Health to include Aboriginal status identification levels of employees in annual Health Performance Agreements, with a goal of each local health network having at least 80% of employee records with an Aboriginal identifier by 2016.
10. SA Health to report on and address by July 2015 why it has not met the South Australia's Strategic Plan target for 2% of its workforce to be Aboriginal across all classification levels by 2014, in particular:
 - a. What parts of the 'Aboriginal Workforce Reform Strategy' and the 'Aboriginal Employment Policy' have not worked for attracting, keeping and increasing Aboriginal employment as they were intended.
 - b. Why the number of Aboriginal workers has gone down over the last three years, especially men, and what strategies may address this.
 - c. Making sure no Aboriginal-identified positions will be lost due to any further funding cuts.
 - d. Working with universities to make pathways for existing enrolled nurses to become registered nurses.

Chapter 2: Introduction

2.1: Background

Under the *Health Care Act 2008*, Aboriginal and Torres Strait Islander people are recognised as ‘having a special heritage and the health system should, in interacting with Aboriginal people and Torres Strait Islanders, support values that respect their historical and contemporary cultures’⁶ (our emphasis). The Act takes this concept of respect a step further by stating that ‘some groups within the community should be able to access special or enhanced health services,’⁷ including Aboriginal people.

In our 2008-2010 review of the health system, *Reflecting on Results*, we assessed South Australia’s public health system performance against the Aboriginal health objectives in its strategic plan. We found Aboriginal health outcomes remained unacceptable and access was limited to services which were culturally appropriate and relevant to the needs of Aboriginal people.⁸ While there were encouraging instances of successful programs, we found there was no demonstration of overall improved health outcomes for Aboriginal people.

In response to our 2010 findings, SA Health said its involvement in the National Indigenous Reform Agreement and its *Aboriginal Health Care Plan 2010-2016* would provide a systematic approach to Aboriginal health care and deliver key outcomes. The *Aboriginal Health Care Plan 2010-2016* was released in October 2010 and was created ‘to ensure health care services can cater to the distinct needs of South Australia’s diverse Aboriginal population’ and ‘to make good health a focus and a priority.’⁹

SA Health also noted in its response to *Reflecting on Results* that the COAG National Partnership on Closing the Gap in Indigenous Health Outcomes would drive improvements.¹⁰

Our consultation with community and clinicians in 2011-12 highlighted that some progress has been made in some areas, which is supported by quantitative data on improving rates of low birthweight for example. Yet there are also continuing challenges, such as shortcomings in access to culturally appropriate services. We therefore again reviewed the status of Aboriginal health and the health system’s response to it during 2011-2014.

2.2: Scope

Given the many aspects which contribute to or detract from Aboriginal South Australians’ health, the scope of this case study is limited by necessity. To determine areas of highest priority, we focused on:

- specific issues which we said in our 2010 report we would examine again
- priorities in *Aboriginal Health Care Plan 2010-2016*, SA Health’s framework for investment in Aboriginal health, and
- areas which Aboriginal leaders told us were particularly important to their communities.

Chapter 3 starts with priority determinants and measures of Aboriginal health drawn from the *Aboriginal Health Care Plan* and chosen in consultation with Aboriginal leaders (see the Appendix). Chapter 3 then explores how the trends and variations in the determinants of health and health status come together in the lives of Aboriginal people in South Australia.

Chapter 4 focuses on the actions of public, private and community-controlled health care services to respond to the health status of Aboriginal South Australians. We note major health system activity in this chapter and its impact on health outcomes.

In Chapter 5, we examine in-depth a major enabler for providing safe and quality healthcare for Aboriginal South Australians: Aboriginal employment in the health sector.

Throughout our case study, we also had a closer look specific topics in the ‘In focus’ sections throughout this document. These sections begin with the commitments made by health agencies then include an evaluation of the extent to which these commitments have been met.



Want to Know More?

Want to check out **SA Health's Plan for Aboriginal health** care for yourself? View the Plan at SA Health's website, www.sahealth.sa.gov.au.¹¹

What to know more about **who we consulted**? You can see the full list of people consulted during this case study in the Appendix, 'People Consulted.'

Interested in what other research is out there? Check out the **Closing the Gap Clearinghouse** at www.aihw.gov.au/closingthegap.

Chapter 3: How Healthy are Aboriginal South Australians?

3.1: At a glance

Together with Aboriginal leaders, we have chosen these measures from our *State of Our Health: Aboriginal Population Compendium* as standout improvements and challenges in the health outcomes of Aboriginal South Australians.

✓ Strengths ✗ Challenges

Determinants:

The social and political environment shapes the health of Aboriginal people

- ✓ 34% of Aboriginal people living in remote SA **speak an Aboriginal language** at home, compared to 7% of all Aboriginal South Australians and 11% nationally [1-2].
- ✓ 85% of Aboriginal people in remote SA **went to an Aboriginal cultural event** in the last year, slightly higher than 74% of all Aboriginal South Australians [1-3].
- ✓ 75% of Aboriginal people in remote SA spent a fair bit or heaps lot of **time on Country** compared to 32% of all Aboriginal South Australians [1-4].
- ✓ **More South Australian Aboriginal students are staying in high school**, with retention increasing 21 percentage points since 2008 to 69%. SA does much better than nationally, which has a retention rate of 51% [1-5].
- ✗ **A 20 percentage point gap** remains between Aboriginal and non-Aboriginal high school retention [1-5].
- ✗ Of Aboriginal people in remote SA, nearly half had days when they **ran out of money** for food, clothing or household bills in the last year compared to 24% of all Aboriginal South Australians [1-6].
- ✗ At 18%, South Australian **Aboriginal unemployment** is three times the overall state unemployment [1-7].
- ✗ Aboriginal **home ownership** is half that of non-Aboriginal rates. Only 34% of Aboriginal South Australians own their house outright or with a mortgage [1-9].
- ✗ **15 times more Aboriginal South Australians are imprisoned** than non-Aboriginal people. The rate is higher than nationally and has doubled since 2003 [1-12].



Getting the Best Start in Life:

The foundations of adult health are laid in early childhood

- ✓ Less Aboriginal women are **smoking during pregnancy** [2-2].
- ✗ Aboriginal women are still about **4.5 times more likely to smoke** during pregnancy than non-Aboriginal South Australians [2-2].
- ✓ **Low birthweight has been decreasing** among South Australian Aboriginal women since 2005 [2-3].
- ✗ **Twice as many Aboriginal babies in SA have a low birth weight** as non-Aboriginal babies [2-3].

Staying Healthy and Ageing Well:

Reducing risk factors increases life expectancy

- ✗ Aboriginal South Australians have **the highest rate of psychological distress** in the country [3-4].
- ✗ Aboriginal South Australians are more than **two times more likely to smoke** than non-Aboriginal South Australians [3-12].

Living with Chronic Conditions:

Effective management of long term illnesses reduces risk of complications

- ✓ 36% of Aboriginal South Australians have **three or more long term conditions**, similar to 41% of all South Australians [4-1].
- ✗ The SA Aboriginal rate of having multiple long-term conditions is slightly above the national Aboriginal average [4-1].
- ✗ 1 in 10 Aboriginal South Australians has a **doctor-diagnosed mental health problem** [4-2].

Causes of Death for Aboriginal People:

Reducing preventable deaths will close the life expectancy gap

- ✗ The South Australian Aboriginal suicide rate is twice that of non-Aboriginal South Australians [5-7].



3.2: What is health?

One of our core functions is to advise the Minister for Health about the health outcomes for South Australians and particular population groups where appropriate.¹²

The importance of an understanding of population health status to being able to evaluate the health system cannot be understated. Effective health services are designed to respond to the people they serve. Therefore a thorough understanding of

- the diversity of Aboriginal South Australians
- the current health status of Aboriginal South Australians, and
- the factors contributing to and detracting from Aboriginal health

is critical to developing health system responses for Aboriginal South Australians.

Health in an Aboriginal context is a concept much larger than an individual's physical wellbeing. It includes an individual and collective sense of agency, as well as social, emotional, spiritual and environmental wellbeing.¹³ The health of Aboriginal people and communities is therefore impacted by the broader social, political and economic context. Health outcomes reflect not only the performance of the health system but also other social and economic institutions.

We have designed our work around the knowledge that health inequalities are a result of structured unfairness and largely result from the impact of social and economic conditions. These impacts determine risk of illness, capacity to maintain health and well-being, and the ability to gain access to health services. We have long asserted that efforts to reduce social disadvantage contribute to health equity.

We created the *State of Our Health: Aboriginal Population Compendium* (the Compendium) as a resource on what is known and measured of Aboriginal health status. We used this information as our foundation for evaluating health system activity.

The Compendium presents trends and variations across a long list of indicators related to health status, health care outcomes, and health system performance for Aboriginal people in South Australia. You can check out all the sixty-eight indicators in the Compendium for yourself at www.hpcsa.com.au.

The first section of this chapter seeks to integrate the variety of quantitative data in the Compendium to create a picture of Aboriginal South Australians' health. All data in this section is limited by the level of identification of Aboriginal people in the datasets. We also know that data alone can never give us the complete picture, but information in Section 3.3 presents the part of the story that we can glean from the *State of Our Health Aboriginal Population Compendium*.

In Sections 3.4 and 3.5, we have a close look at two health status issues the health system has identified as priorities, low birth weight and immunisation.



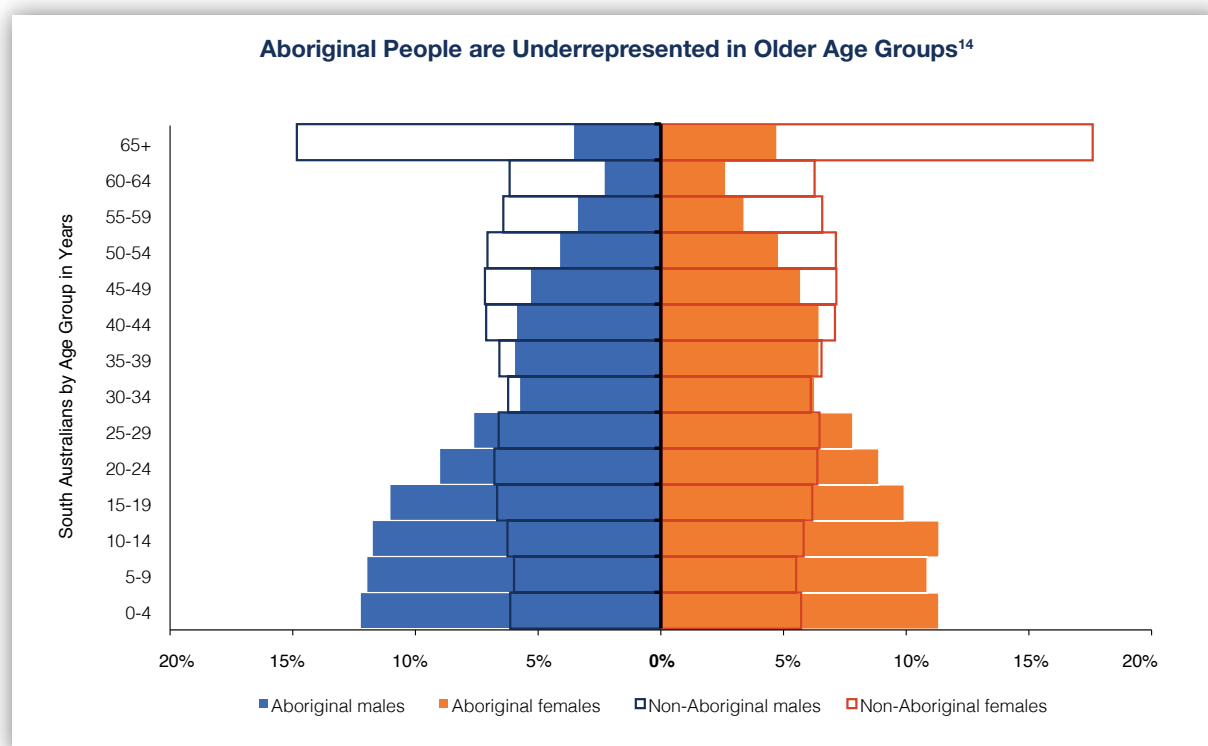
3.3: Imagine two cousins, a boy and a girl, born today...

3.3.1: ...As children

Aboriginal children born today in South Australia could expect to have different experiences than non-Aboriginal children throughout their lives, including factors impacting health.

The cousins would join over 30,000 Aboriginal people living in South Australia – 1 in every 50 South Australians. They would be just as likely to be born in the Adelaide metropolitan area as in one of the state's rural or remote areas, as half of Aboriginal South Australians live in country areas.

Regardless of where they lived, they would be more likely to have siblings than their non-Aboriginal neighbours. At the same time, they would be much more likely to attend the funerals of their aunts, uncles and grandparents as Aboriginal South Australians are underrepresented in all age groups over 30 years old.



Although they could expect a higher chance to live to their first birthday than their cousins born before them, their chance would be lower than the average baby in South Australia. They could also expect to not live as long as their non-Aboriginal neighbours. Although the data is not available for South Australia, nationally an Aboriginal baby girl can expect to live to 72.3 – almost 12 years less than a baby girl born to her non-Aboriginal neighbours. An Aboriginal baby boy can expect to live to 67.4 – 12.5 years less than a non-Aboriginal boy and 5 years less than his sister.

When the cousins reached year 5 at school, they would be at higher risk than their non-Aboriginal classmates and cousins interstate of not achieving the national minimum standards in reading and numeracy. If they lived in a very remote area, like the far north and west of the state, they would be even less likely to achieve these standards.

As they progressed in school, the cousins would be more likely to stay in school to year 12 than their cousins in most other states. This would increase their likelihood of accessing healthcare and participating in the labour market later in life.¹⁵

3.3.2: ...In their family

If the cousins' family lived in remote SA, they would have a one in three chance of living in a household where the main language spoken was an Aboriginal one. Their chance would drop to 1 in 16 if their family lived in rural SA. It would be even lower if they lived in Adelaide, as just fewer than 2% of Aboriginal people living in metropolitan Adelaide speak an Aboriginal language as their main language at home.

The cousins would be more likely than their non-Aboriginal neighbours to be born into a family experiencing housing stresses. Decent and affordable housing is a cornerstone of good health and a major determinant of health inequalities.¹⁶ Their families would have only a one in three chance of owning or buying their own home, around half that of their non-Aboriginal neighbours. Their parents would have an almost a one in five chance of facing unemployment. This is three times higher than non-Aboriginal South Australians and one of the highest rates among Aboriginal people across all Australian jurisdictions.

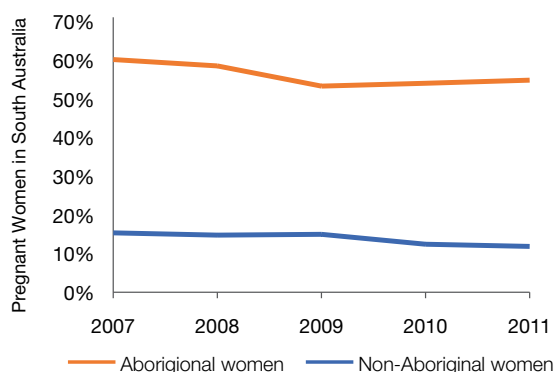
Their family would also have a one in four chance of being significantly impacted by financial stress. Nearly 25% of Aboriginal South Australians reported that there were days in the last year when they had run out of money to buy food, clothing, or pay household bills – rising to 45% in remote SA (most areas outside of the greater Adelaide, Fleurieu, Yorke and Mid North and Southeast regions). Their family may also face the challenge of having a family member in custody. The Aboriginal imprisonment rate in South Australia is almost 15 times the non-Aboriginal rate, the third-highest Aboriginal imprisonment rate in Australia.

As they got older, the female cousin could expect to have two or three children, compared to one or two for South Australian women overall.

She would be five times more likely to smoke during pregnancy than her non-Aboriginal neighbours, but she would be less likely to do so than her cousins would have done in the past. Despite these challenges, her pregnancy would be more likely to result in a live birth than pregnancies of non-Aboriginal South Australian women. As a South Australian Aboriginal woman, she would also have the greatest likelihood of having a live birth in Australia.

Regardless, her children would have twice the risk of having a low birth weight than other babies in the hospital and a slightly higher risk than the average Australian Aboriginal baby. This could potentially result in her baby being more vulnerable to illness as a child and as an adult, and could in turn impact future generations.¹⁸

Smoking During Pregnancy is Decreasing but a Gap Remains (second half of pregnancy)¹⁷



3.3.3: ...In the community

The likelihood of the cousins growing up to be involved in Aboriginal cultural activities would be very high, with nearly three quarters of Aboriginal South Australians involved in at least one Aboriginal cultural activity over the last year. The cousins would also be reasonably likely to spend time caring for Country, with almost a third of Aboriginal people in SA spending a 'fair bit/heaps' of time on Country. This would depend on where the cousins lived, with the rate much higher in remote SA, at nearly 75% of Aboriginal people, compared to just over 10% in metropolitan Adelaide.

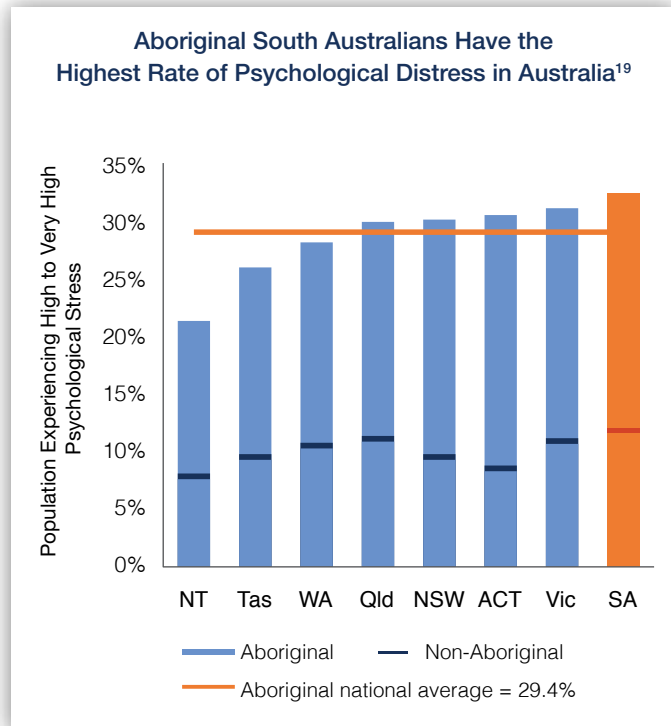
As adults, the cousins would be likely to report they are in good health, similar to their cousins interstate. Despite their perception of being in good health, they would be two and a half times as likely to experience psychological distress as South Australians overall. This is the highest rate of any state or territory in Australia.

Yet the likelihood of the cousins receiving a diagnosis from a doctor of having a mental health condition would be similar to their non-Aboriginal neighbours if they lived in the metropolitan area. If they lived in a regional area, their likelihood of being diagnosed as having a mental health condition would be even lower, only one-third that of their urban cousins and non-Aboriginal neighbours.

The cousins would only be slightly more likely than their non-Aboriginal neighbours to drink alcohol at risky levels, and less likely than their cousins interstate. Yet they would be twice as likely as South Australians overall to smoke, similar to their cousins interstate.

The cousins would be very likely to include Aboriginal traditional foods in their diet, although this would vary greatly depending on where in SA they lived. More than half of Aboriginal people in SA eat traditional Aboriginal foods, but this ranges from nearly 90% in remote SA to 20% in metropolitan Adelaide. However, the cousins would be unlikely to eat the recommended amount of fruit or vegetables. They would only have a one in two chance of being physically active as frequently as recommended. These risk factors mean the cousins would have a 70% chance of being overweight or obese, slightly below the national average for Aboriginal people and a bit higher than all South Australians.

They would likely face some health challenges, including having a one in three chance of having three or more long-term health conditions. They would have a one in four chance of developing high blood pressure and diabetes or 'a touch of sugar.' They would also have a high chance of developing kidney disease, as 6.1% of Aboriginal South Australians have kidney disease compared to only 0.7% of all South Australians. The cousins' likelihood of developing kidney disease would be much higher if they lived in a remote area, as nearly one in five Aboriginal South Australians who live in remote areas have doctor-diagnosed kidney disease.



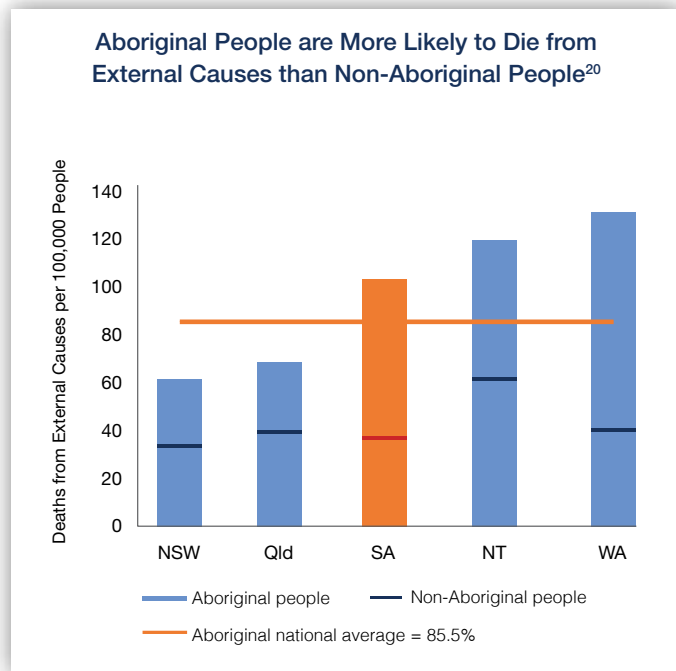
The likelihood of the cousins developing asthma would be twice that of non-Aboriginal South Australians and higher than the national average for Aboriginal people. They would also have a one in ten chance of having a heart or circulatory problem, similar to Aboriginal Australians overall.

The cousins would be part of an Aboriginal community in SA that says it has very high levels of health literacy. More than 90% of Aboriginal South Australians say information from their doctor helps them understand why they need to take prescribed medication. When asked, over 70% indicate that they read the instructions with new medicines most times or always. Most say they do not find it difficult to understand information provided with medicines and are able to take their medication as directed. Similarly, the overwhelming majority of Aboriginal people say they are very or quite confident in filling out medical forms.

3.3.4: ...At the end of life

The death rate among the Aboriginal population in South Australia is higher than the non-Aboriginal population but lower than most other states reporting this data.

Yet the likelihood of the cousins dying by external causes, such as accidents, self-harm and assault, would be three times their non-Aboriginal neighbours. This is higher than the national average. The cousins would also be more than twice as likely to commit suicide as non-Aboriginal South Australians, which is similar to Aboriginal people in other states.





3.4: In focus: Low birth weight

At a glance

- Aboriginal women are twice as likely as non-Aboriginal women to have a baby with a low birth weight, which puts the baby at risk for complications early in life as well as during their adult years.
- SA Health has created clear targets, engaged Aboriginal people in program design, resourced antenatal services to Aboriginal women, and monitored and reported on progress. These actions have been important levers to positive outcomes, including:
 - An increase in antenatal visits for Aboriginal women
 - A decrease in smoking among pregnant Aboriginal women, and
 - A decrease in the percent of low birth weight Aboriginal babies.

In depth

Ensuring a healthy start in life is a priority action area in SA Health's *Aboriginal Health Care Plan*, yet the system has been challenged by high rates of low birth weight Aboriginal babies.²¹ Low birth weights are associated with complications after birth, disabilities and chronic disease later in life.²² Improving outcomes for Aboriginal babies is also a target in South Australia's Strategic Plan, which aims to 'reduce the proportion of low birth weight babies and halve the proportion of Aboriginal low weight babies by 2020.'²³ The baseline of this target is 2003, when the rate was 17.3%, meaning the target is 8.7% of births to Aboriginal women by 2020.

SA Health said it would address this challenge by ensuring 'all Aboriginal women have access to best practice care antenatal, birthing, postnatal and parenting programs and services as near as possible to where they live.'²⁴ SA Health's *Framework for Comprehensive Primary Health Care Services for Aboriginal People* specifies what this care looks like, including that:

- 'all women [have] culturally safe and appropriate antenatal care to commence as close to 10 weeks gestation as possible
- antenatal check-ups be offered and facilitated at regular intervals throughout pregnancy depending on the needs of each woman. In the case of a first pregnancy, the South Australian Perinatal Practice Guidelines recommend 8 visits [...]
- childbirth is to occur in a culturally and clinically safe environment [...]
- women are to be identified early for risk associated with pregnancy
- processes must be in place to ensure women assessed as being at high risk can access services most appropriate to their needs and clear referral on service permission pathways are established to support this.'²⁵

The Framework also refers to relevant guidelines which guide practice. Together, these documents are sufficiently detailed enough to provide both direction to services as well as monitoring of progress.

In fact, indications are that there has been progress. While the percentage fluctuates yearly due to the relatively small number of births to Aboriginal women, there seems to be a slow downward trend. In 2005, 17.7% of Aboriginal babies born in South Australia weighed less than the 2500 grams²⁶ which the World Health Organization defines as low birth weight.²⁷ By 2011, the rate had declined to 15.2%.²⁸

The Aboriginal Family Birthing Program is SA Health's flagship program to improve antenatal outcomes for Aboriginal women and their babies. Since 2010, the program has sought to provide culturally appropriate antenatal care with an Aboriginal workforce.²⁹

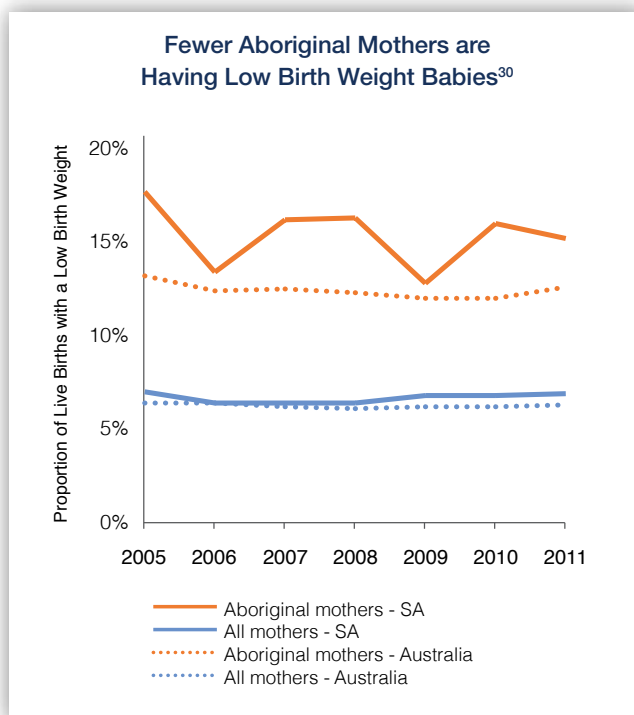
The Aboriginal Family Birthing Program served 174 women in 2011,³¹ approximately a quarter of the 693 Aboriginal women who gave birth in South Australia that year.³² The number of women served by the program increased to 235 in 2012.³³

The Government of South Australia has identified this program as a strength, listing its implementation as a highlight of the health portfolio's actions in multiple state budget papers,^{34,35} and feedback from Aboriginal leaders is that the program is well-respected in the Aboriginal community.

Positive movements in birth weights are likely partially due to an accompanying reduction in Aboriginal women smoking during pregnancy, which in turn may have been influenced by SA Health's targeted anti-smoking campaigns.³⁶ An increase in antenatal visits from 40.5% of pregnant Aboriginal women in 2007 to 54.6% in 2010³⁷ is also a likely contributor to these improved outcomes.

The seemingly small reduction in the proportion of Aboriginal babies born with a low birth weight is a hard-won improvement. The South Australia's Strategic Plan Audit Committee rates this target as within reach of being achieved by 2020.³⁸ The continuance of programs dedicated to addressing this complex issue will be important to meeting this target and reducing the percentage of Aboriginal children born below the recommended birth weight in the long-term.

The success in this area illustrates the value of setting targets, engaging and employing Aboriginal people, appropriately resourcing programs and monitoring for outcomes.



Want to Know More?

Check out the HPC's *Aboriginal Population Compendium* at www.hpcsa.com.au.

These measures may be of particular interest if you want information related to low birth weight:

Fertility rate [2-1], Smoking during pregnancy [2-2], Low birth weight [2-3-1], Perinatal deaths [5-3], Infant mortality [5-4], Access to nurse or midwife [6-3], Antenatal visits in South Australia [6-6], Employed nurses and midwives [10-1-2].

3.5: In focus: Immunisation

At a glance

- The South Australian immunisation rate for Aboriginal children is the lowest of all jurisdictions, with nearly one in four Aboriginal five year olds not vaccinated as recommended.
- SA Health has termed the low rate 'a significant community risk.'³⁹
- Some efforts have been made to improve the rate, but they seem limited compared to the extent of this gap and it is too early to know their impact.

In depth

Preventative actions like immunisation are important to avoiding not only poor health outcomes for individuals and communities but also unnecessary cost burdens on the health system. During our process of evaluating the health status of South Australians during 2011-2014, we identified the low rate of Aboriginal immunisation as one of the most significant challenges to the South Australian health system.⁴⁰

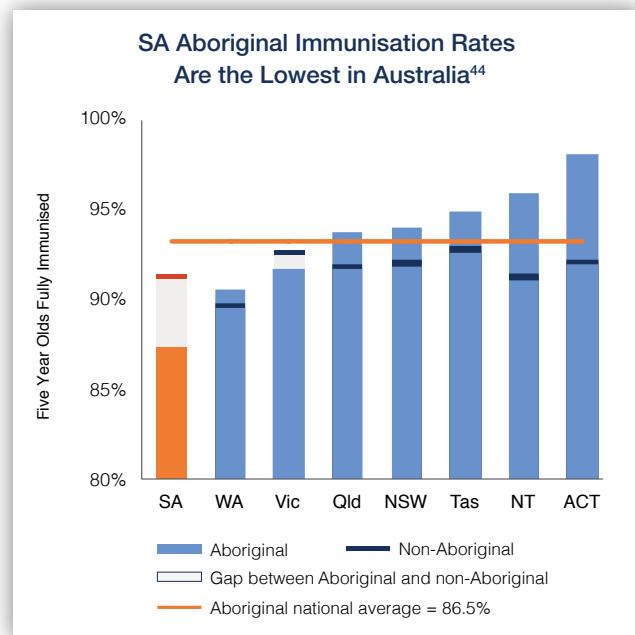
The South Australian immunisation rate for Aboriginal 5 year olds in 2011, 78.7%, was the lowest of all jurisdictions and well below the Australian Aboriginal average of 86.5%.⁴¹ This was a small improvement from the rate in 2010, 76.3%, but still 8.6 percentage points below the non-Aboriginal rate. It is also well below the 92% coverage SA Health states is required for effective population disease prevention, creating what SA Health has termed 'a significant community risk.'⁴²

The *Aboriginal Health Care Plan* states child health and a healthy start in life are in its main priority action areas, with postnatal and child health checks listed as priority initiatives.⁴³

SA Health's *Framework for Comprehensive Primary Health Care for Aboriginal People* lists as a core element that all families, irrespective of where they live, will be offered immunisation for their children and supported to immunise during regular postnatal reviews and through reminders at every clinic visit.⁴⁵

SA Health's actions to meet this target include public awareness campaigns and creating the position of Aboriginal Immunisation Coordinator in the Northern Adelaide local health network (LHN).⁴⁶ This role supports improved access and immunisation outcomes in that LHN, but there is no reported similar role in any of the other four LHNs. Without additional evidence, it is not possible to know what efforts are being made in these areas to meet SA Health's commitments.

As counting rules for immunisation have changed,⁴⁸ comparable data is only available from 2010, so it is too early to know the impact of these initiatives. It is clear, though, that sustained efforts will be required to close this important gap and protect the health of Aboriginal South Australian children, now and into the future.



Want to Know More?

Check out the HPC's *Aboriginal Population Compendium* at www.hpcsa.com.au.

These measures may be of particular interest if you are seeking information related to immunisation:

Child mortality [5-5], Access to GP or doctor [6-2], Childhood immunisations [6-7], Children's health checks [6-8], Potentially preventable hospitalisations [8-2].

Chapter 4: How is the Health System Working for Aboriginal People?

4.1: At a glance

Together with Aboriginal leaders, we have chosen these measures from our *State of Our Health: Aboriginal Population Compendium* as standout improvements and challenges in the South Australian health system's response to Aboriginal South Australians' health.

✓ Strengths ✗ Challenges

Getting into the System:

Are Aboriginal people accessing the right care, at the right place, at the right time?

- ✓ More Aboriginal South Australians with **fair or poor health access health services** than Aboriginal people nationally [6-1].
- ✓ More Aboriginal women are having **antenatal assessments** since 2007 [6-6].
- ✗ 45% of pregnant Aboriginal women in SA do not have an antenatal assessment before 14 weeks gestation compared to 20% of non-Aboriginal women [6-6].
- ✓ More Aboriginal **4 year olds are receiving health checks** since 2010-11 [6-8].
- ✗ Only 38% of Aboriginal 4 year olds in SA receive a check, compared to 72% of Aboriginal children nationally [6-8].
- ✓ **More older Aboriginal people are receiving health assessments** since 2009-10 [6-9].
- ✗ SA lags behind other states, with only 21% of older Aboriginal South Australians having assessments compared to 30% nationally [6-9].

Being Treated Well:

Are Aboriginal people cared for by the health system with respect?

- ✗ Few Aboriginal people have **chronic disease management plans**. Only one in six Aboriginal people in SA with diabetes and only one in five with coronary heart disease have a management plan [7-2].
- ✗ Less than half of Aboriginal people **hospitalised for psychiatric reasons receive follow-up** in the week after discharge [7-4].

Getting Good Outcomes:

Do Aboriginal people receive safe, relevant services?

- ✗ Aboriginal SA inpatients discharge against medical advice more than four times more often than non-Aboriginal inpatients and the rate is not improving [8-4].

Being Done Efficiently:

Does the health system achieve results with the most effective use of resources?

- ✓ 7% of Aboriginal South Australians receive **public sector clinical mental health services**, higher than nationally, which may mean more need is being met in SA [9-4].





4.2: Getting into the system

In Chapter 3, we found that Aboriginal South Australians experience worse health outcomes in many important areas. In this chapter, we focus in on a short, targeted list of indicators which spotlight areas of the health system's performance in response to these needs.

We do not report on every available indicator related to Aboriginal health, but intentionally only consider health system performance measures that align with priority areas.

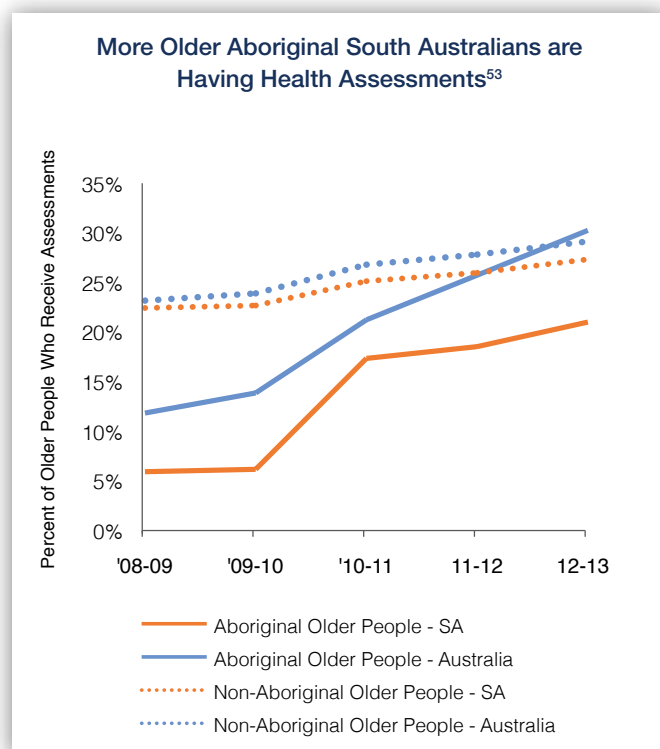
We assessed key indicators of whether Aboriginal South Australians are getting into the health system, in particular to what extent they are accessing the right care, at the right place, at the right time.

Given existing health outcomes for Aboriginal people, we started by examining the level of access to healthcare compared to what we know about need. The Australian Health Ministers' Health Council has suggested that 'Aboriginal and Torres Strait Islander peoples currently experience significantly poorer health and therefore we should expect to see access to health services 2-3 as high' as non-Aboriginal people.⁴⁹

We heard from Aboriginal people during consultations that there were challenges to access to appropriate health services for Aboriginal people, but there were positive stories, too. With nearly 60% of Aboriginal people with fair or poor health accessing health services, this rate is highest of the states and territories.⁵⁰ The South Australian Aboriginal rate is also higher than the 48.3% of all South Australians with fair to poor health and report accessing health services. This is a positive outcome, but given the level of need, it is clear that efforts to improve access to health services for Aboriginal people must continue.

Antenatal visits for pregnant Aboriginal women have been trending up, with the 40.5% of pregnant Aboriginal women in 2007 receiving an antenatal visit before 14 weeks gestation increasing to 54.6% in 2011.⁵¹ Yet a significant gap between Aboriginal and non-Aboriginal rates remains, with nearly 80% of non-Aboriginal South Australian women having their first antenatal visit before 14 weeks gestation. See Section 3.4: In focus: Low birth weight for more information.

Rates of Aboriginal children receiving the recommended health checks have been trending up. In 2012-13, 37.8% of Aboriginal four year olds received a health check, more than twice the percent of four year olds who received the check in 2009-10.⁵² Yet the SA Aboriginal rate remains about half of the national Aboriginal average of 72%, and is lower than that of non-Aboriginal children in South Australia, 48.4% of whom received the recommended check in 2012-13.



Rates of annual health assessments for older people have been trending up. The annual health assessment rate of Aboriginal people aged 55 or older has increased four-fold in the last five years, with about one in five older Aboriginal South Australians now receiving the recommended annual health assessment.⁵⁴

Despite this improvement, the South Australian Aboriginal rate remains below the national Aboriginal average of almost one in three older people receiving the assessment. It is also below the non-Aboriginal rate of older people (defined for non-Aboriginal people as those 75 and older) of 27.3%.



4.2.1: In focus: Identification

At a glance

- Not all Aboriginal people are correctly identified as Aboriginal when they go to hospital. Under-identification of Aboriginal people can make it difficult to measure and monitor Aboriginal population health.
- South Australia's rate of correctly identifying Aboriginal people in public hospitals increased from 87% in 2007 to 91% in 2011-12.⁵⁵
- SA Health has made improving Aboriginal identification a priority goal to be achieved by mid-2013. It provided staff training in 2010-11 and 2012-13 as a strategy to meet this goal, but it is unclear the scale of the training or how effective it may have been.

In depth

We found in our 2010 review that a lack of coding Aboriginal status in datasets limited health data quality and made some analyses impossible.⁵⁶ As noted by the Australian Institute of Health and Welfare (AIHW), under-identification of Aboriginal people in health data can make it difficult to:

- measure the health of Aboriginal people and how it may be different from non-Aboriginal people
- understand Aboriginal people's service preferences
- understand which services improve outcomes for Aboriginal people,
- monitor changes in the health and service use of Aboriginal people over time.⁵⁷

The Australian Health Ministers' Advisory Council states improved identification of Aboriginal people is particularly important for addressing the gap in management of chronic disease.⁵⁸

Although a move toward improving quality, the process of increasing identification can make monitoring changes in health status and services particularly challenging. For example, a hospital may report an increase in Aboriginal clients, but this increase may not signify increased need due to ill health. It is very difficult to know the cause of such an increase from data alone as multiple factors may have an impact, including improved identification, awareness about the service, or cultural competency resulting in clients feeling more comfortable accessing the service.

In response to concerns that there may be under-identification of Aboriginal patients in hospitals, the AIHW designed and conducted audits of identification in public hospitals in 2005,⁵⁹ 2010⁶⁰ and 2013.⁶¹ Due to AIHW's work in this field and the above-mentioned concerns, SA Health included increasing levels of identification of Aboriginality in hospital data systems as a priority goal in its *Aboriginal Health Care Plan 2010-2016*.⁶² SA Health's 2011 annual report on the Plan listed this initiative as a medium term priority, meaning it was due to be achieved by mid-2013.⁶³

Given that there is no precise indicator for this goal, it is impossible to determine if it has been achieved. There has been progress, though. In its 2010 audit, AIHW estimated that only 87% of Aboriginal people in South Australian hospitals in 2007 were identified correctly in hospital admission records, compared to 89% across Australia.^{64,65}

By 2011-2012, AIHW estimated that this proportion had improved and that 91% of Aboriginal patients in South Australian hospitals were correctly identified in hospital separation data.⁶⁶ In these four years, South Australia's rate surpassed the national one, which reduced to 88%, seemingly due to a significant reduction in the completeness of data in New South Wales.

SA Health is using the standard Indigenous status question and recording categories as recommended by the Australian Institute of Health and Welfare.⁶⁷ SA Health also funded the Australian Bureau of Statistics to develop a package to train frontline staff to correctly and appropriately identify patients.⁶⁸ AIHW reports that the training was delivered to more than 430 staff in 40 locations during its rollout in 2010-11 and that a second and final round was due to be conducted in 2012-13.⁶⁹

There is no available evidence of how many people received the training in 2012-13, how it may have changed processes or if further training is planned. Training to ensure identification levels continue to improve is a crucial element to providing appropriate services and monitoring their impact.

Want to Know More?

Check out the HPC's *Aboriginal Population Compendium* at www.hpcs.com.au.

Appropriate identification impacts the accuracy and usefulness of all performance data in the Compendium. You may be particularly interested in indicator 7-1, Aboriginal people who identify as Aboriginal when asked by a health service.

4.2.2: In focus: Local implementation

At a glance

- Local implementation plans were supposed to be developed in 2010 to support implementation of the *Aboriginal Health Care Plan 2010-2016*.
- The plan created and implemented by the Women's and Children's health network is comprehensive.
- At the time of writing, four years into a six year plan, South Australia's other four local health networks (LHNs) had not produced an implementation plan. Although there was activity related to Aboriginal health in these areas, it is difficult to determine what overarching goals these LHNs are trying to achieve for their populations without plans.

In depth

The *Aboriginal Health Care Plan 2010-2016* set a framework for regional implementation through regional Aboriginal Health Improvement Plans, also called LHN Aboriginal Health Care Implementation Plans.⁷⁰ These plans were to:

- outline how health services would implement the *Aboriginal Health Care Plan* at a regional level
- be developed in 2010
- be included in Health Performance Agreements between the Chief Executive of SA Health and the Chief Executive Officers of regional services (now LHNs)
- be reported on annually in progress reports.⁷¹

The plans were one of SA Health's two priority actions to ensure an integrated and collaborative approach to planning and delivery for Aboriginal health.⁷²

The Women's and Children's LHN launched its Aboriginal Health Improvement Plan, 'Making Aboriginal Health and Wellbeing Everyone's Business,' in 2012.⁷³ The comprehensive plan outlines the specific issues faced by this health network and its priorities to address them.

The Country Health SA LHN refers to a plan in its latest annual report⁷⁴ but this plan is for its COAG primary health care initiatives,⁷⁵ not SA Health's *Aboriginal Health Care Plan 2010-2016*. As such, it covers only primary health care, not the full range of services Country Health provides to Aboriginal people.

Four years into a six year plan, four of South Australia's five LHNs have not produced local implementation plans. SA Health states that these LHNs are currently preparing plans.

Yet as this action was listed as a priority, was to be completed in 2010, and is important to ensuring the Aboriginal Health Care Plan is implemented, this is unsatisfactory. The Health Performance Council would expect that these LHNs would be preparing quality local implementation plans which will address the specific needs of Aboriginal people in their areas by taking into account the existing vast knowledge base on Aboriginal health status and health service use. As a starting point, sources include SA Health's Health Information Portal, local health networks' and Medicare Locals' previous consultations with Aboriginal people, and the information in this report.

Subsequent to the HPC providing the draft of this report to SA Health for factual clarification, local implementation plans for 2014 to 2016 were provided to the HPC. We understand these plans have not been endorsed by the Health Portfolio Executive, but in general, these plans contain few measurable performance measures. It will therefore not be possible to measure their impact and determine whether they achieve their goals.

4.3: Being treated well

Once South Australians access the health system, they expect to be treated well. Our key indicators for Aboriginal South Australians being treated well are chronic disease management and follow up after a hospital visit for psychiatric reasons.

Chronic diseases are the major cause of morbidity and mortality for Aboriginal people and therefore management of these conditions is key in closing the gap in health outcomes between Aboriginal and non-Aboriginal people.⁷⁶ Yet SA Aboriginal rates of care planning for clients with chronic disease are below national Aboriginal averages across the four categories reported.

For Aboriginal South Australians with diabetes, only 15.7% have a General Practice Management Plan,⁷⁷ a plan a general practitioner develops to support a person with a chronic or terminal condition manage treatment.⁷⁸ For Aboriginal South Australians with diabetes, 11.4% have a Team Care Arrangement,⁷⁹ meaning the person's general practitioner is coordinating ongoing care from a multidisciplinary team of three or more providers.⁸⁰ Both of these rates are approximately half those of the national averages.⁸¹

The rates of Aboriginal South Australians with coronary heart disease who have chronic disease management plans are also lower than the national rate. More than one in five (22.3%) Aboriginal people with coronary heart disease have a General Practice Management Plan, compared to one in four nationally (28.1%). One in six (16.7%) have a Team Care Arrangement, compared to one in five (22.3%) nationally.

We understand that SA Health provides some primary care services in addition to the services included by Medicare data above. Unfortunately, SA Health advises it does not collect data for Aboriginal primary health services not covered by Medicare Benefits Schedule billing services, so the extent of these services is unknown.

As highlighted in Chapter 3, Aboriginal South Australians have the highest rate of high to very high psychological distress in Australia. We also heard from Aboriginal leaders that mental health is the single most important issue to their communities. For system performance in this area, we were particularly interested in whether Aboriginal people who accessed hospital services were treated well and with respect to support them to achieve wellbeing and a productive life.

The time after being released from hospital is a particularly vulnerable time for people whose treatment was for mental health reasons. Follow-up from health services in a timely manner reduces the risk of recurrence; the COAG National Action Plan on Mental Health therefore contains a target of 75% of mental health inpatients receiving follow-up within seven days of hospital separation.⁸² Yet more than half of Aboriginal people discharged from a psychiatric admission to a public hospital in South Australia do not get community follow-up within seven days.⁸³

While there was no Australian average for this measure published at the time of writing, the South Australian rate was well above that of Tasmania (22.8%) but half of the highest ranked jurisdiction, the ACT, at 87.9%. There is also a gap between Aboriginal and non-Aboriginal rates in South Australia, as 45.2% of Aboriginal people discharged from a psychiatric admission receive follow-up, compared to 52.0% of non-Aboriginal South Australians.

4.3.1: In focus: Culturally competent services

At a glance

- SA Health has clear commitments to provide culturally competent services. Yet there is limited evidence of their widespread implementation, monitoring or evaluation.
- SA Health has committed to providing access to a traditional healer for patients who request one. While 1 in 13 Aboriginal South Australians say they have accessed a traditional healer in the last year, there is no evidence of how many clients have accessed traditional healers through SA Health.

In depth

During our 2010 review of the public health system, we evaluated workforce cultural competence. We found that more needed to be done to ensure the health workforce was culturally competent to deliver responsive health services to Aboriginal people.⁸⁴ We also found that cultural competence was not systematically monitored or evaluated.⁸⁵



SA Health has committed to safe and quality services for Aboriginal people by supporting a culturally responsive health system.⁸⁶ SA Health's commitment to culturally competent services includes:

- 'implementing the Cultural Respect Framework for SA Health in 10 per cent more services each year
- providing resources for cultural competency training and ensuring a systemic approach to its delivery across the state
- establishing cultural security policy, protocols and standards in hospitals and health services.'

SA Health states it has commenced implementing its Cultural Respect Framework.⁸⁷ Yet there is no evidence of the baseline number of services using the Framework or developing Aboriginal health impact statements (a requirement of the Framework), nor the number in subsequent years.

Development of Aboriginal health impact statements is mandatory for any proposal across SA Health which is considered by the department's executive or any local health network's executive.⁸⁸ SA Health has developed guidelines to help with their development,^{89,90} yet there is little evidence of their systematic monitoring as required by the Cultural Respect Framework.⁹¹ From the available evidence, it is difficult to cite much improvement in the systematic monitoring or evaluation of cultural competence by health services or the people who work in them.

Likewise, in 2012, SA Health stated it had agreed to a three-tiered approach to training staff to provide culturally respectful and competent services⁹² but there is limited evidence of its implementation and to what percentage of employees. In 2013, the Country Health LHN stated more than 200 staff had attended training⁹³ but there was no information on other LHNs.

As for the cultural security policy, protocols and standards, SA Health states development of these documents were at an early stage at the end of 2012.⁹⁴ As this was a short to medium priority, it should have been completed by mid-2013,⁹⁵ but evidence of their completion is lacking.

Traditional Aboriginal healers are an important element to providing the holistic health care central to Aboriginal definitions of health and therefore a culturally competent health system. SA Health asserts 'Ngangkari [traditional Aboriginal healers] play a vital role in shaping the lives of Aboriginal people and influencing and managing a person's spiritual and physical wellbeing.'⁹⁶ It also committed that, 'where Aboriginal people request the support of a Ngangkari, SA Health staff must respect the wishes of a patient and facilitate access.'

Despite this commitment, in 2011 SA Health acknowledged there was neither a consistent way to access traditional healers nor a referral process, so stated it would review ways to support involvement of traditional healers by mid-2013.⁹⁷ SA Health did develop a referral process through the Statewide Traditional Healers Program (Ngangkari Brokerage Program), but by the end of 2012, its implementation seemed limited and was only in some locations.⁹⁸

It is unlikely access needs are being met by the Aboriginal community-controlled sector, as the Aboriginal Health Council of South Australia states that as of 2010 there were no community-controlled services employing Ngangkari.⁹⁹ It is unknown how many people may have accessed a traditional healer privately or via a referral from other sectors.⁹⁹

Yet some people are accessing traditional healers. One in every thirteen Aboriginal South Australians says they have seen a traditional healer in the last year. Of the 157 people in the metropolitan area surveyed in the South Australian Aboriginal Health Survey in 2012, 10 (6.4%) said they had visited a traditional healer in the last year.¹⁰⁰ In rural and remote areas, 25 of the 242 (10.3%) people surveyed had visited a traditional healer. It is unknown how these people accessed the traditional healer, for what health conditions, or whether mainstream health care was also accessed for the condition being treated.

SA Health states it is facilitating access to female traditional healers and has developed a *Recognised Traditional Healer Framework*. Evidence could not be found, though, of how many people are accessing traditional healers through SA Health's brokerage program, nor when, in what region, or for how many visits. Without this information, it is not possible to determine if SA Health is meeting its intentions.



Want to Know More?

Check out the HPC's *Aboriginal Population Compendium* at www.hpcsa.com.au.

These measures may be of particular interest if you are seeking information related to culturally competent services:

Access to health services [6-1, 6-2, 6-3], Access to Aboriginal health worker [6-4], Access to traditional Aboriginal healer [6-5], Antenatal visits in South Australia [6-6], Aboriginal people who identify as Aboriginal when asked by a health service [7-1], Self-discharge from public hospital and discharge from hospital against medical advice [8-4], Aboriginal primary healthcare, episodes of healthcare [9-1-2], Health workforce [10-1-1], Employed nurses and midwives [10-1-2], Employed medical practitioners [10-1-3], Aboriginal employees in SA Health [10-1-4].



4.4: Having good outcomes

One of our key functions under the *Health Care Act 2008* is to report on whether the health system is achieving good outcomes for South Australians.¹⁰² In our 2010 report, we noted surveys conducted by SA Health found that the majority of Aboriginal patients reported they were treated differently by hospital staff because they were Aboriginal.¹⁰³

Patients leaving hospital without being officially discharged by treating clinicians is a clear but indirect measure of whether people's expectations are being met, such as whether they feel they are receiving quality care which will lead to good outcomes. In 2010, we found that, while still a small proportion of all hospital patients, the rate of Aboriginal people who discharged themselves from public hospitals was nearly five times that of non-Aboriginal patients. We noted in 2010 that the proportion of Aboriginal patients who discharge against medical advice¹⁰⁴ seemed to be starting to trend downward between 2007-08 and 2009-10.¹⁰⁵

The small fluctuation between 2007-08 and 2009-10 in Aboriginal people discharging themselves from public hospitals has not continued. There was no noticeable change over the last five years, either in the percent of Aboriginal people discharge against medical advice or the ratio to non-Aboriginal patients.¹⁰⁶ In 2012-13, 3% of all Aboriginal inpatients in South Australian public hospitals discharged against medical advice, nearly four times the rate of non-Aboriginal inpatients (0.7%). The rate is particularly high in country regions, where it is 4%.

The significant gap between Aboriginal and non-Aboriginal rates of discharge from hospital against medical advice remains and requires urgent attention. We will explore this issue further in our report on the 2011-2014 performance of the health system.

4.4.1: In focus: Drug, alcohol and tobacco use

At a glance

- Aboriginal South Australians are more likely than non-Aboriginal South Australians to present to emergency departments for alcohol and drug related reasons. There has been no improvement in these rates in the last four years.
- Smoking rates for Aboriginal South Australians have reduced from 47% in 2007-08 to 40% in 2012-13 but remain much higher than rates for non-Aboriginal people. While this reduction is positive, it is unlikely the South Australia's Strategic Plan target to reduce smoking will be met in its timeframe.
- Cross-government efforts to reduce harm to Aboriginal people from drug, alcohol and tobacco use may be having an impact.

In depth

The whole of government commitment to improve the lives of South Australians through an evidence-based response to illicit drug and alcohol misuse is the *South Australian Alcohol and Other Drug Strategy 2011-2016*.¹⁰⁷ The Strategy lists as one of its five objectives to 'reduce harm from substance misuse among Aboriginal people,' and has clear actions and measures. It is monitored annually through reports on program and KPI progress.

Aboriginal South Australians are only slightly more likely to drink alcohol at levels considered risky, with 51% of South Australian Aboriginal people reporting they have drunk at a level which could cause injury or death in the last twelve months,¹⁰⁸ compared to 44% of all South Australians.¹⁰⁹ In 2010, about 15% of all South Australians said they had used an illicit drug in the last year.¹¹⁰ Directly comparable data is not available for Aboriginal South Australians, but about a quarter of Aboriginal South Australians in 2008 reported using an illicit drug in the previous year.¹¹¹



We heard from Aboriginal leaders that alcohol and substance misuse cause disproportional damage in Aboriginal communities. This was confirmed in emergency department data. Despite a similar proportion of the population using substances, Aboriginal people are much more likely than non-Aboriginal people to present to emergency departments for alcohol-related reasons, with 17.9% of alcohol-related emergency department presentations in 2013-14 by Aboriginal people, rising to more than one in three alcohol presentations (35.1%) for country residents.¹¹² There is some indication that the rate of alcohol presentations by Aboriginal people has increased since 2011-12, when only 11.3% of presentations to emergency departments were for alcohol-related reasons.

Aboriginal people are also overrepresented in emergency department presentations due to drug-related issues, with about one in every ten (9.6%) drug-related presentations in 2013-14 by an Aboriginal person.¹¹³ The rate for country residents rises to one in six (16.6%) drug-related presentations. The statewide rates have remained relatively steady for the last four years.

The majority of Government programs aimed at reducing the harm from substance misuse are on track, including:

- assessing the most comprehensive primary prevention strategies through collaboration with the Aboriginal Health Council of South Australia
- training Aboriginal workers to respond to alcohol and other drug issues through the Certificate III in Community Services (Alcohol and Other Drugs), which had 16 graduates in 2012
- providing culturally appropriate services through the Aboriginal Substance Misuse Connection Program which had 189 referrals in 2011-12, and
- establishing a Day Centre in Ceduna in 2012 to work with people experiencing problems caused by substance misuse.¹¹⁴

While it is positive that programs are on track, it is too early to tell if these programs are having their intended effects. The lack of change in emergency department presentations may indicate that they are not.

In our review of South Australians' health status, we found Aboriginal smoking prevalence to be one of the greatest challenges for the health system.¹¹⁵

SA Health is the lead agency to progress South Australia's Strategic Plan (SASP) target to 'reduce the smoking rate to 10% of the population and halve the smoking rate of Aboriginal South Australians by 2018.'¹¹⁶ The baseline for this target is 2007-08 data, at which point 47% of Aboriginal South Australians smoked and 17.4% of all South Australians did. The target for Aboriginal smoking is therefore a rate of 23.5% in 2018.

In the five years to 2012-13, the rate had reduced 7 percentage points to 40%,¹¹⁷ which was more than twice the rate of South Australians overall.¹¹⁸ Regardless, the gap between Aboriginal and non-Aboriginal smoking rates had actually reduced, as the smoking rate for all South Australians continued to be 17.4%. Given these figures, it is highly unlikely the SASP target will be met for either Aboriginal South Australians or South Australians overall in the next four years as planned.

It is impossible to attribute this reduction to any specific initiative, but it may have been influenced by SA Health's 'Give up smokes for good' campaign. SA Health piloted the culturally-specific public anti-smoking campaign in 2011 and fully rolled it out in 2012. Program evaluation has shown that those exposed to the campaign were more likely than those who were not to be aware that smoking caused illness (88.9% v 80.5%) and that passive smoking is harmful (84.0% v 73.2%).¹¹⁹ Importantly, current smokers were more likely to have attempted to quit in the previous year (54.2% v 34.0%).

These results are encouraging. Reducing rates of smoking is important to reducing the gap between health outcomes between Aboriginal and non-Aboriginal South Australians. Yet much more will be needed to reduce the rate another 16.5 percentage points in the next four years to meet the SASP target.





Want to Know More?

Check out the HPC's *Aboriginal Population Compendium* at www.hpcsa.com.au.

Many indicators in the Compendium impact and are impacted by drug, alcohol and tobacco use. These measures may be of particular interest if you are seeking information related to substance use:

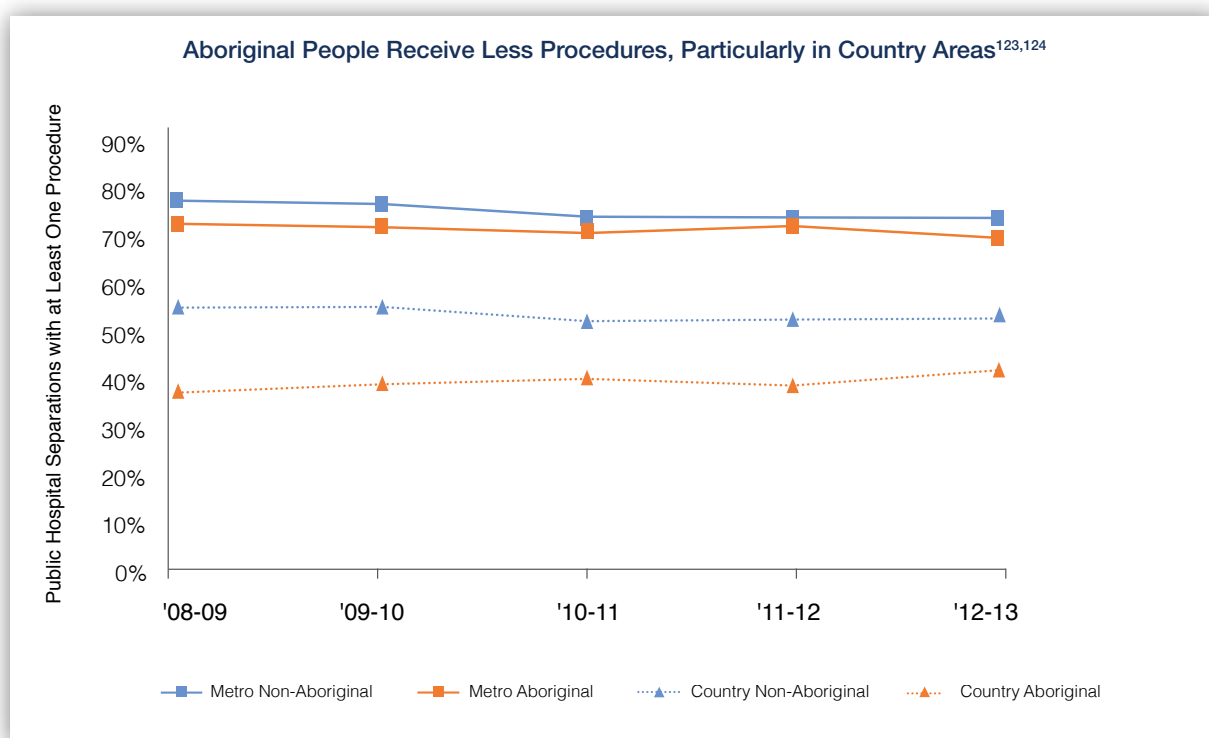
Smoking during pregnancy [2-2], Psychological distress [3-4], Alcohol risk [3-10], Smoking [3-12], Mental health problems [4-2].

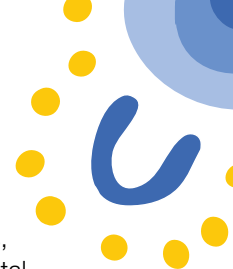
4.5: Being done efficiently

In our Working Framework for Reviewing Health System Performance, we identified that health system performance is more than providing quality health services. The efficiency and sustainability of the health system are also crucial elements of its performance, particularly its ability to work efficiently and achieve results with the most effective use of its resources. Efficiency includes the capacity to sustain its workforce and infrastructure while responding to emerging needs.

Nationally, although Aboriginal people are more likely to be hospitalised than non-Aboriginal people, they are less likely to receive a medical or surgical procedure while in hospital.¹²⁰ Research has showed that disparities in procedures exist across diagnoses, including for coronary heart disease, cancers and kidney disease.¹²¹

We examined the rates of hospitalisations without procedures in South Australia. We found that the national trend is reflected in South Australia and that Aboriginal people are less likely to receive any procedure when in hospital.¹²² Over the last decade, the differential access to hospital procedures between Aboriginal and non-Aboriginal South Australians has averaged around 15 percentage points. In 2012-13, this meant that more than two in every five Aboriginal South Australians considered sick enough to be admitted to hospital left that hospital without receiving a procedure.





There is also a consistent gap between metropolitan and rural and regional patients over the last five years, with all country South Australians, Aboriginal and non-Aboriginal, less likely to receive a procedure in hospital than people in the metropolitan area. In 2012-13, only 41.4% of Aboriginal hospitalisations in a country hospital received a procedure and only 52.5% of non-Aboriginal hospitalisations did.

While rates of procedures for Aboriginal patients in South Australia in 2012 were the same as the national average for Aboriginal people, South Australia was ranked sixth of the eight Australian jurisdictions, with a significantly higher gap than four other jurisdictions.¹²⁵

This is a significant waste of resources and a clear inefficiency – when people access the health system but do not receive the care required, not only is their admission less likely to create the desired outcomes, they are more likely to be readmitted.

Knowing the proportion of the population receiving mental health care is another way to measure whether service delivery is meeting need.¹²⁶ In South Australia, 6.9% of Aboriginal people received public sector clinical mental health services in 2011-12.¹²⁷ This rate has consistently tracked above national Aboriginal average over the last five years.

As previously stated, the Australian Health Ministers' Health Council suggests Aboriginal people should access health services two to three times as often as non-Aboriginal people to address the significantly poorer health outcomes they face.¹²⁸ In this case, Aboriginal South Australians are accessing public sector clinical mental health services at around four times the non-Aboriginal rate of 1.7%.

The relatively high rate of the Aboriginal population in South Australia receiving clinical mental health services could be a positive indication of Aboriginal people feeling more comfortable accessing services. Alternatively, it could indicate increased need due to inefficiencies in other parts of the health system, for example lower rates of receiving follow-up after previous psychiatric admissions as discussed in 'Section 4.3: Being treated well.' It could also indicate increased need due to social determinants, as South Australian Aboriginal people have the highest rate of psychological distress of any Australian jurisdiction and almost three times that of South Australians overall.¹²⁹

4.5.1: In focus: Mental health

At a glance

- Psychological distress among Aboriginal South Australians is a major concern for Aboriginal communities. The rate of high to very high psychological distress is nearly three times the rate of South Australians overall and the highest of any Australian jurisdiction.¹³⁰
- Aboriginal people are accessing mental health services at relatively higher rates than non-Aboriginal people, but people we consulted remain concerned about the cultural appropriateness of available services and if the extent of the need is being met.

In depth

In our 2010 review of the health system, we found reducing the gap in mental illness between Aboriginal and non-Aboriginal South Australians was a significant challenge for the health system.¹³¹ We were not alone in our findings; the South Australian Social Inclusion Board's *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform* also found that South Australia required dedicated effort to provide culturally competent mental health services for Aboriginal people – but that the system was capable of rising to the challenge.¹³²

We said we would assess this issue again during our 2011-2014 review. When we considered the many indicators of South Australians' health status during this review, we found psychological distress among Aboriginal people to be one of the greatest challenges the health system faces.¹³³ Psychological distress among Aboriginal people is exceptionally high, the highest of any Australian jurisdiction and almost three times that of South Australians overall.¹³⁴

Removal from family is a potential contributor to this disparity, an issue particularly pertinent in light of a history of forced removal of Aboriginal children. Of Aboriginal South Australians living in the metropolitan area, 16.4% have been removed from their natural family at some point,^{135,136} compared to 7.5% in regional areas¹³⁷ and 8.2% in remote areas.¹³⁸



In the metropolitan area, 50.7% of Aboriginal people have relatives who were removed from their natural family,¹³⁹ compared to 36.1%¹⁴⁰ and 29.8%¹⁴¹ for regional and remote areas, respectively.¹⁴²

Mental health remains the single most important health issue for Aboriginal people. Importantly, mental health outcomes are a crucial part of other health outcomes. SA Health lists Aboriginal social and emotional health and mental illness as a priority and has made commitments that it will provide appropriate mental health services responses for Aboriginal young people and the wider Aboriginal community.¹⁴³

Yet people we consulted during our mental health case study in 2012-13 had ongoing concerns about the accessibility of mental health services for Aboriginal people. In particular, the lack of knowledge of available services which is an accessibility barrier for country residents is more keenly experienced by Aboriginal people in regional areas.

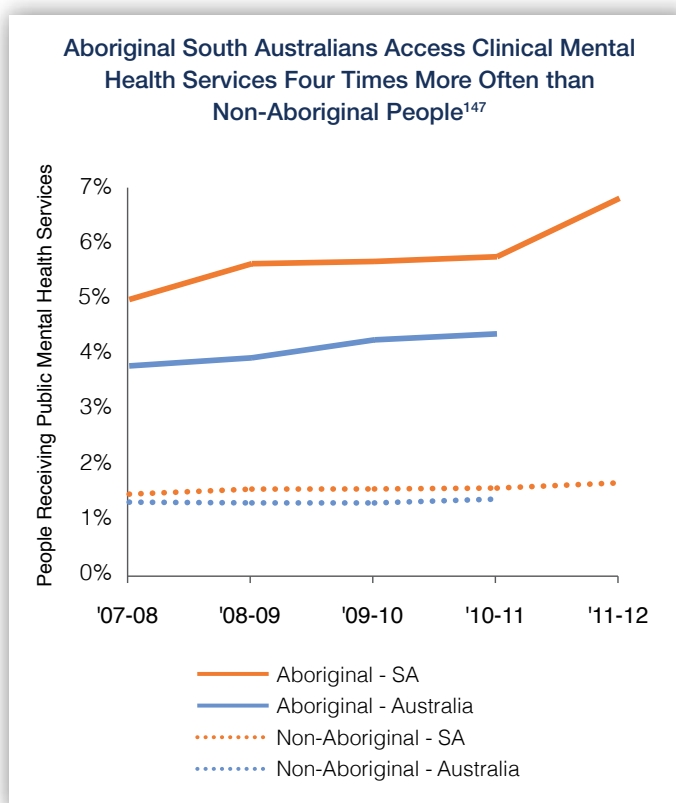
Communities perceive that the lack of culturally competent services has a detrimental impact on people accessing services they need. The South Australian Public Advocate has also commented on the need for culturally safe and accessible mental health services, noting that despite some progress, improving mental health outcomes for Aboriginal people has been 'painstakingly slow.'¹⁴⁴

During our mental health case study, we found it very difficult to access data on service use by Aboriginal South Australians as very little data is available by both region and Aboriginal status. What we do know is that Aboriginal South Australians are using community-based mental health services at more than three times the rate of non-Aboriginal South Australians, with near 970 community-based mental health service contacts per every 1,000 Aboriginal people.¹⁴⁵ This rate has doubled in the last five years and mirrors an overall increase across Australia for Aboriginal people.

We also know 6.9% of all Aboriginal people used a public clinical mental health service in 2011-12, four times the non-Aboriginal rate, and that this rate has been increasing over the last four years.¹⁴⁶ This increase could be a positive indication of Aboriginal people feeling more comfortable accessing services or it could indicate increased need.

The entire story is unknown, as well, without private clinical service information. Given levels of relative disadvantage among Aboriginal South Australians outlined in Chapter 3, it is possible non-Aboriginal people are accessing private services more than public.

Despite the additional use of these services, Aboriginal South Australians are less likely than non-Aboriginal to receive follow up within seven days of being discharged from hospital for a mental health issue,¹⁴⁸ increasing their chances of relapse and therefore making them more likely to need acute services again in the future.



Want to Know More?

Check out the HPC's *Aboriginal Population Compendium* at www.hpcs.com.au.

Many measures in the Compendium impact or are impacted by mental health. These measures may be of particular interest if you are seeking information related to mental health:

Aboriginal culture [1-2, 1-3, 1-4], Income security [1-6], Unemployment [1-7], Overcrowded households [1-10], Imprisonment rate [1-12], Profound or severe disability [3-2], General health status [3-3], Psychological distress [3-4], Social and emotional well-being [3-5], Smoking [3-12], Long-term health conditions [4-1], Mental health problems [4-2], Deaths from external causes [5-6], Suicide rate [5-7], Access to GP or doctor [6-2], Access to Aboriginal health worker [6-4], Access to traditional Aboriginal healer [6-5], Care planning for clients with chronic disease [7-2], Community follow-up after discharge from a psychiatric admission [7-4], Self discharge from public hospital and discharge from hospital against medical advice [8-4], Community-based ambulatory mental health service contacts [9-3], Public sector clinical mental health services [9-4].

Chapter 5: Are Aboriginal People Involved in Care?

5.1: At a glance

- Aboriginal employment in the health sector is a key enabler to improve Aboriginal population health, yet Aboriginal people are underrepresented in the health sector.
- Aboriginal employment at SA Health has decreased since 2011. SA Health has not met South Australia's Strategic Plan target for 2% of employees to be Aboriginal by 2014.
- A barrier to monitoring this important contributor to Aboriginal health is accurate and complete recording of employees' Aboriginal status in the public sector. The Aboriginal status is unknown for nearly half of SA Health employees.
- The Aboriginal community-controlled sector is a very important part of the health care system for Aboriginal people. It provides primary care to more than half of South Australia's Aboriginal community with a small number of staff.
- The private health sector employs a very small number of Aboriginal employees but does well identifying its workforce's Aboriginal status.

5.2: Importance

Health services provided by Aboriginal people for Aboriginal people are known to improve Aboriginal population health outcomes. The World Health Organization states that health programs for indigenous people should have 'active participation at the local level in the whole process ... cultural sensitivity of health services and the participation of health care workers of indigenous origin.'¹⁴⁹

The Australian Institute of Health and Welfare (AIHW), Australia's national health statistics agency, asserts health care provided by Aboriginal people is a strategy to 'improve health care and increase the health status and life expectancy of the Indigenous population.'¹⁵⁰ At a state level, SA Health states 'Aboriginal participation through employment...is crucial in achieving quality service provision and equitable health outcomes.'¹⁵¹

In addition, there is evidence that Aboriginal people see value in health services employing Aboriginal people. In October 2013, the HPC conducted a forum of Aboriginal leaders from across South Australia. The Aboriginal leaders attending stated that their foremost priority for review within the health system was the Aboriginal health workforce.

The HPC notes these state, national and international authorities' acknowledgment of the importance of Aboriginal people providing health care. Importantly, these bodies recognise that Aboriginal employment in health professions is essential not only to improving Aboriginal representation in an important area of professional life, but to create better health outcomes.

The health industry in Australia is a significant one, with 6% of all working Australians employed by in the industry in 2006.¹⁵² In South Australia, the health industry comprised an even larger proportion of the workforce, with more than 7% of the total workforce working in health occupations.¹⁵³ The health industry is also a significant employer for Aboriginal South Australians, with 5.5% of Aboriginal employees in South Australia working in a health occupation in 2006.¹⁵⁴

The Aboriginal health workforce is employed in health practitioner roles and roles without client contact across three sectors: the Aboriginal community-controlled, the public and the private sectors. Where possible, the HPC has accessed data across these sectors and presented its findings below.





5.3: Aboriginal community-controlled sector employment

In the 2011-12 financial year, Aboriginal primary health-care services in South Australia provided care to 17,204 Aboriginal clients, more than half of South Australia's Aboriginal population.¹⁵⁵ This is an increase from an estimated 16,590 Aboriginal clients and 19,646 total (Aboriginal and non-Aboriginal) clients in 2009-10.¹⁵⁶ This increase in clients was accompanied by an even greater increase in activity, with AIHW reporting less than 200,000 episodes of care in 2008-09 and 2009-10¹⁵⁷ in South Australia to just below 250,000 episodes in 2010-11.¹⁵⁸

Relative to the clientele it serves, the community-controlled sector has a very small workforce. For example, a 2010 workforce needs analysis conducted by the Aboriginal Health Council of South Australia found that all but one Aboriginal community-controlled health services in South Australia had a general practitioner to population ratio of 1:2,000 or more people.¹⁵⁹ Australia wide, there was a GP to population ratio of double that, with 111.8 GPs to every 100,000 Australians in 2012,¹⁶⁰ equivalent to approximately 2.4 GPs per every 2,000 Australians, Aboriginal and non-Aboriginal.

In 2011-12 in South Australia, there were 423 full-time equivalent positions working in this sector.^{161,162} While the AIHW does not publish these data by Aboriginal status, more than half of the more than 3,000 staff nationwide that worked in an Aboriginal primary health-care service in 2012 and who recorded an Aboriginal status identified as Aboriginal.¹⁶³ If the ratio of Aboriginal to non-Aboriginal employees was the same in South Australia, this would be the equivalent of 225.2 full-time equivalent positions filled by Aboriginal South Australians,¹⁶⁴ including 74.9 health practitioners.¹⁶⁵

5.4: Public sector employment

5.4.1: SA Health policies

SA Health is South Australia's public health provider, consisting of:

- The Department for Health and Ageing, the central department for health policy and strategic directions in South Australia
- Five local health networks, which provide public health services, such as hospital services, and
- The SA Ambulance Service.¹⁶⁶

SA Health has made a 'firm commitment to increasing the employment of Aboriginal people at all levels of our organisation and the retention of current and future Aboriginal employees' in its Aboriginal Employment Policy.¹⁶⁷ This mandatory directive commits all South Australian health regions to increase their proportion of Aboriginal employees and develop a regional Aboriginal employment strategy.

SA Health's 'Aboriginal Workforce Reform Strategy,' developed to put the policy into action, further states SA Health will attract, retain and develop Aboriginal employees while monitoring and evaluating its progress on these goals.¹⁶⁸ The Aboriginal Health Scholarship Program, co-funded by the Australian Rotary, is a significant initiative to support Aboriginal South Australians to become qualified or improve their qualifications to work in the South Australian Public Health Sector.

5.4.2: South Australia's Strategic Plan

In addition to SA Health's policies, South Australia's Strategic Plan (SASP) has a target to increase representation of Aboriginal people across the whole of the public sector workforce. Target 53 of the SASP is 'Aboriginal employees: Increase the participation of Aboriginal people in the South Australian public sector, spread across all classifications and agencies, to 2% by 2014 and maintain or better those levels through to 2020.'¹⁶⁹

Improving representation of Aboriginal people in health professions would also contribute to other SASP Targets:

- 6. Aboriginal wellbeing: Improve the overall wellbeing of Aboriginal South Australians
- 26. Early childhood – birth weight: Reduce the proportion of low birth weight babies and halve the proportion of Aboriginal low birth weight babies by 2020

- 28. Aboriginal leadership: Increase the number of Aboriginal South Australians participating in community leadership and in community leadership development programs
- 51. Aboriginal unemployment: Halve the gap between Aboriginal and non-Aboriginal unemployment rates by 2018
- 79. Aboriginal healthy life expectancy: Increase the average healthy life expectancy of Aboriginal males to 67.5 years (22%) and Aboriginal females to 72.3 years (19%) by 2020.¹⁷⁰

Other targets in the SASP also contribute to and are impacted by representation of Aboriginal people in health professions.

There are therefore high-level policies committing both the South Australian Government as a whole and SA Health to improve Aboriginal participation.

5.4.3: SA Health employees

SA Health records the Aboriginal status of its employees. Unfortunately, the level of recording of Aboriginal status varies significantly across areas of the agency, ranging in 2013 from 80.4% of full-time equivalent employee records in SA Health's Central Office to only 27.3% in the Southern Adelaide local health network.¹⁷¹ Across SA Health, about 57% of the 30,666 full-time equivalents were identified as Aboriginal or non-Aboriginal.¹⁷² Therefore the Aboriginal status of a large proportion of SA Health employees is unknown.

Note that given this large percentage of unknowns, we have used only information about records which are identified as Aboriginal or non-Aboriginal for our analyses below unless otherwise stated.

During our 2010 review of the public health system, we found that Aboriginal employment across SA Health would not be enough for SA Health to meet the SASP target by its assigned deadline of 2014.¹⁷³

Of the available data which contained information on employee Aboriginal status in June 2013, there were a total of 409 Aboriginal employees in SA Health, which equated to 1.8% of the SA Health workforce whose Aboriginal status was known and 328 full-time equivalents, representing 1.9% of the full-time equivalent workforce.^{174,175}

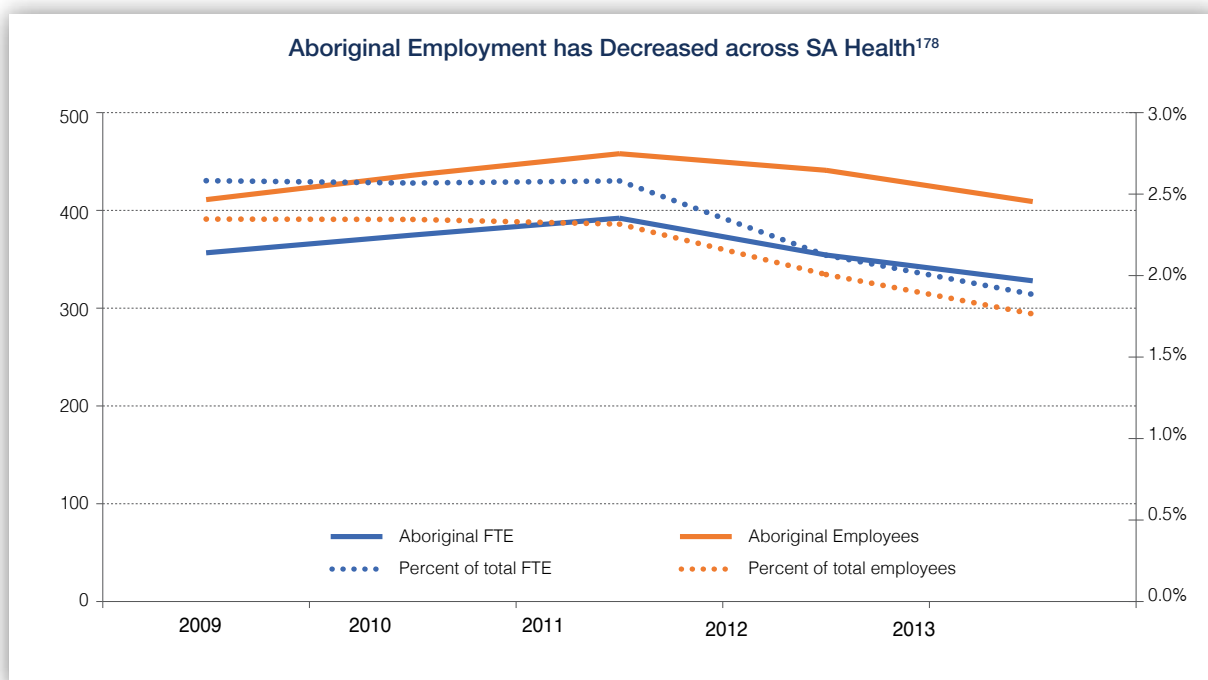
Given such a very high level of employees with unknown Aboriginal status, it is impossible to accurately calculate the number of Aboriginal employees SA Health needs to hire to meet its 2% target. Using the total number of full-time equivalents in June 2013, 613 full-time equivalent positions in SA Health would need to be filled by an Aboriginal person. It is unlikely that identification will ever be 100%, though. Based on current levels of identification, 348 full-time equivalent positions spread across all classifications would need to be filled by Aboriginal people for the SASP target to be met.

Although SA Health has not met the target, the SA Health rate is slightly above the cross-government average. While there has been improvement overall across government agencies since 2004 when only 1.07% of public sector employees were Aboriginal, in 2013 the target was not yet met, with Aboriginal people representing 1.66% of all government employees.¹⁷⁶

Across local health networks (LHNs), representation ranged from 0.7% of employees in the Northern Adelaide LHN to 5.3% of employees in the Women's and Children's Health Network.¹⁷⁷ On numbers, though, Country Health SA LHN was the largest employing LHN. In June 2013, Country Health employed nearly 40% of all SA Health Aboriginal employees, with 124 Aboriginal full-time equivalent positions within this LHN. It has been consistently the largest employing area since 2009.

From 2009-2011, there was little change in the percent of people in SA Health's full-time equivalent workforce who identified as Aboriginal, at about 2.6%. In June 2012, there was a reduction to 2.12%, which decreased again in 2013 to 1.9%. In terms of positions, this was a reduction of 29 full-time equivalent positions filled by Aboriginal employees.

Subsequent to the HPC providing the draft of this report to SA Health for factual clarification, SA Health advised it could achieve 80% identification of SA Health employees by 2016 if it introduced an Annual Census Day for staff to update that their cultural status identifier. SA Health also advised LHNs will implement local Aboriginal workforce improvement strategies. The HPC supports these initiatives and suggests specific performance indicators and timeframes be developed.



Some of this reduction can be attributed to the movement of three services to the Aboriginal community-controlled sector. SA Health states that it expected approximately 100 full-time equivalents to move from the Country Health LHN in 2011-2012 when Pika Wiya, Ceduna Koonibba, and Nunyarra Health Services became community-controlled.¹⁷⁹ It is unknown how many of these positions were filled by Aboriginal employees, but Country Health LHN lost 17.5 Aboriginal full-time equivalents between 2010 and 2011, and a further 30 in 2012.¹⁸⁰

Between 2009 and 2013, there was also a change in the balance of men and women among SA Health's Aboriginal employees. In 2009, 31.9% and 114 full-time positions of SA Health's Aboriginal employees were men, but this consistently reduced over the period to 22.5% and only 74 full-time equivalents.¹⁸¹ Although these are small numbers, they represent a change in gender balance which was not mirrored by non-Aboriginal employees.

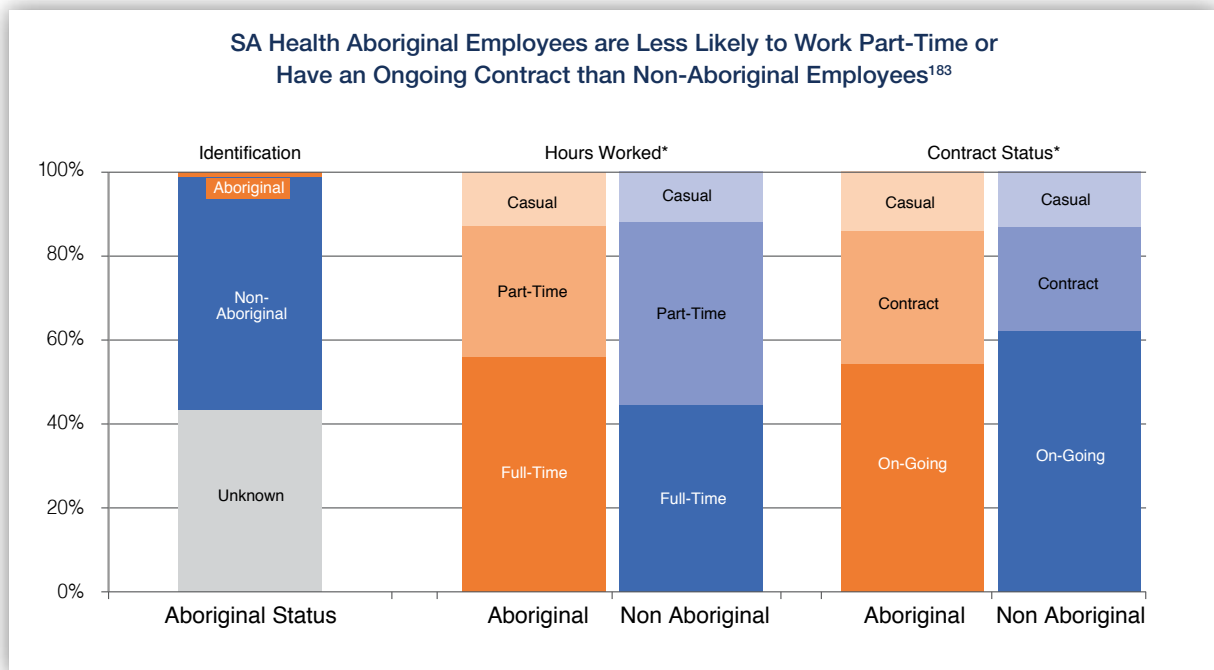
5.4.4: Employment Status and Salary

Aboriginal employees within the public health system in 2013 were more likely to work full-time than non-Aboriginal employees, at 53.5% as compared to 42.7% of non-Aboriginal employees (See figure, next page).¹⁸² Yet they were slightly over-represented in casual work, at 16.2% compared to 15.7%.

Aboriginal employees in the public health system are underrepresented in ongoing employment, with a bit more than half (52.8%) of Aboriginal employees' contacts ongoing, compared to nearly seventy percent (67.3%) of the workforce overall (including those with unknown Aboriginal status). These ratios have not fluctuated much over the last five years.

As previously mentioned, the SASP target is for 2% representation of Aboriginal employees balanced across all classifications. Yet Aboriginal employees in SA Health are over-represented in lower salary ranges.

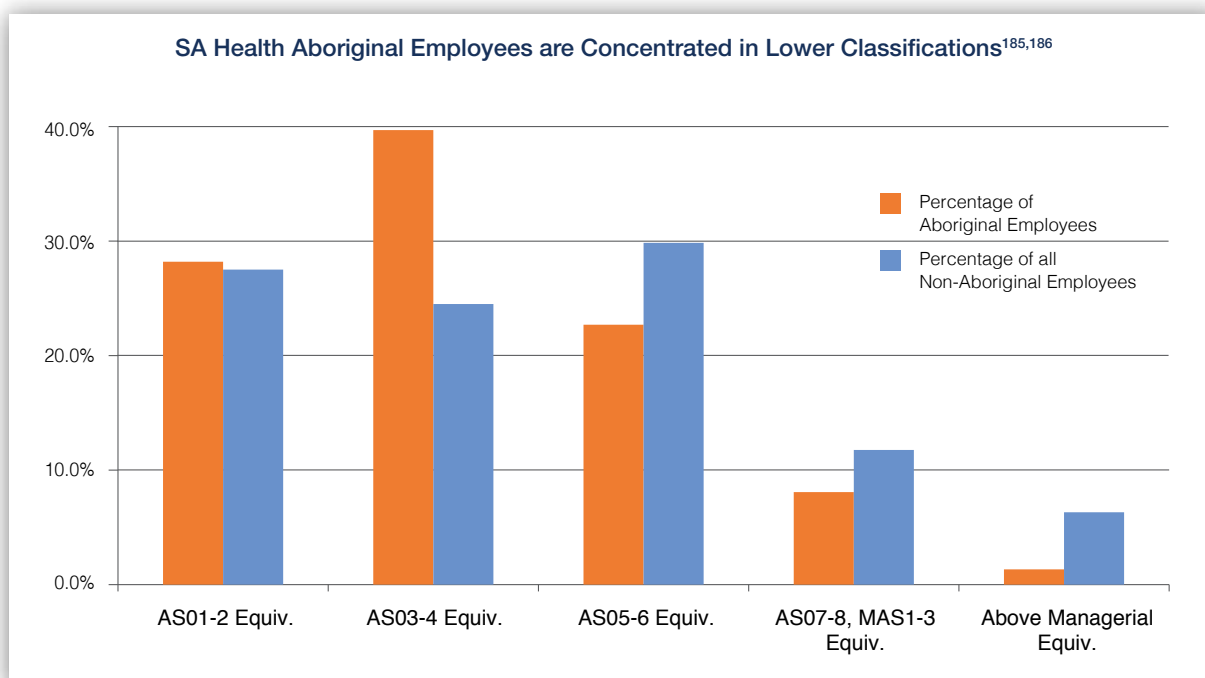
In June 2013, 28.2% of Aboriginal SA Health full-time equivalent employees were working at an ASO1-2 equivalent salary of less than \$53,200 (See figure, next page).¹⁸⁴ This was similar to non-Aboriginal employees, 27.5% of whom are in that salary bracket. Yet two in five Aboriginal employees were in the second lowest range, ASO3-4 equivalent, with 39.7% of Aboriginal employees earning between \$53,200 and \$67,699. This is an over-representation, as only about a quarter (24.5%) of non-Aboriginal employees are in this category.



*Of records with known Aboriginal Status

As the salary ranges increase, so does the relative under-representation. Approximately a fifth (22.7%) of Aboriginal full-time equivalent employees earned between \$67,700 and \$86,500, equivalent to ASO5-6, compared to almost a third of non-Aboriginal employees (29.8%). For ASO7-8 and MAS1-3 equivalent, the rates were 8.1% and 11.8%, respectively. Only 1.3% of Aboriginal employees were earning executive equivalent salaries, compared to 6.3% of non-Aboriginal employees.

While the balance of classifications has changed over the last five years, Aboriginal employees have consistently been overrepresented at ASO1-4 equivalent salaries and under-represented in all higher salary and classification groupings.



5.4.5: Employees by profession

Across the public sector health workforce, there are distinct differences in the representation of Aboriginal people between professions. As stated above, 1.9% of the SA Health's total workforce with a recorded Aboriginal status is Aboriginal. Yet only 0.2% of SA Health's doctors identified as Aboriginal in 2013.¹⁸⁷ Doctors composed less than 2% of SA Health Aboriginal employees, compared to 9.6% of non-Aboriginal employees.

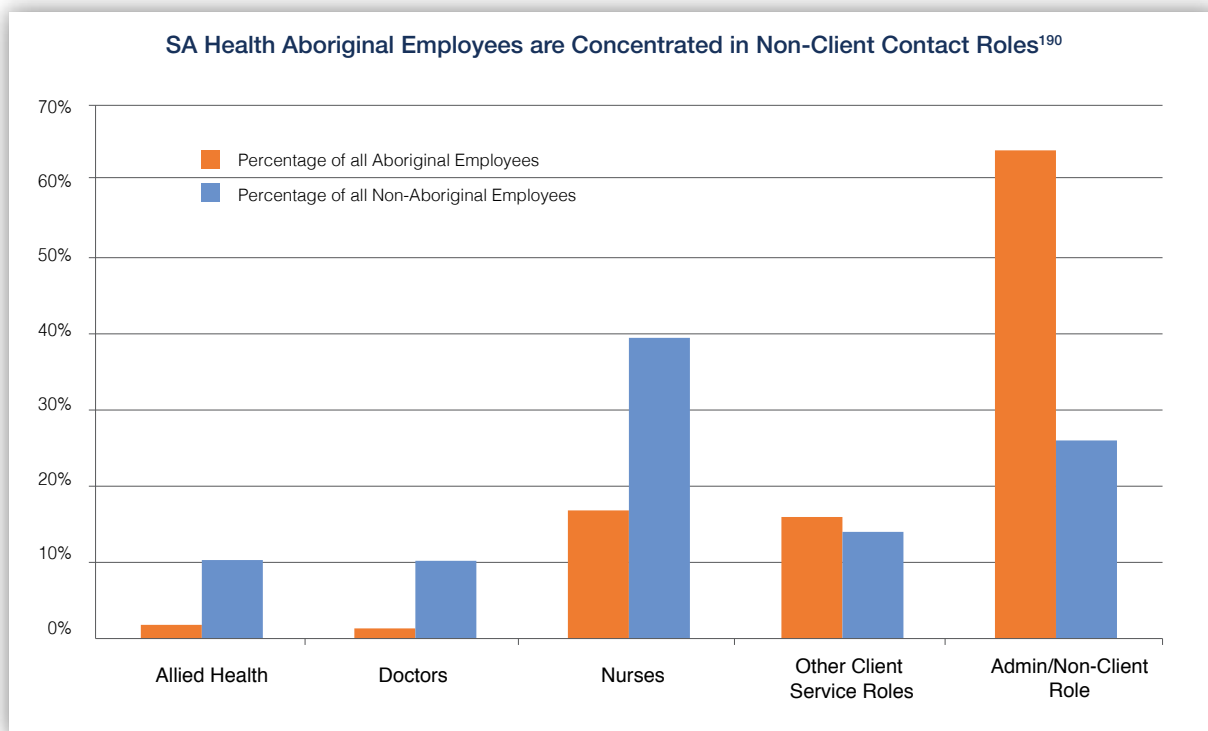
Allied health professionals had a similar representation of Aboriginal workers, with 0.3% of the more than 2,200 public allied health professionals identifying as Aboriginal.¹⁸⁸ Aboriginal people working in the allied health professions represented nearly 2% of the public health Aboriginal workforce, while 9.9% of the non-Aboriginal workforce was employed in an allied health profession.

A large proportion of the public sector health workforce is composed of nurses. Of the almost 9,500 nurses who identified as either Aboriginal or not, 1.0% were Aboriginal.¹⁸⁹ This represents 23.7% of all SA Health Aboriginal employees, an under-representation, as 41.2% of the non-Aboriginal workforce are nurses.

Of the Aboriginal nurses employed by SA Health, they were more likely to be employed at a lower level, with nearly 70% (69.7%) earning in the two lowest salary tiers of up to \$67,699, compared to less than half (48.6%) of non-Aboriginal nurses. Aboriginal nurses were also more likely to be enrolled nurses, with 37.0% of all Aboriginal nurses employed as enrolled nurses, compared to only one in five (19.2%) of non-Aboriginal nurses.

While neither of these ratios is much different than it was in 2009, the raw numbers of Aboriginal nurses have increased. In 2009, SA Health employed 47.3 FTE of Aboriginal nurses, 18.4 of whom were enrolled nurses. By 2013, this FTE had increased to 52.8, 19.5 of whom were enrolled nurses. By count of Aboriginal nurses, the increase is more dramatic, increasing from 64 in 2009 to 97 in 2013. Clearly, efforts to increase the numbers of Aboriginal nurses have had an impact. No other role type has had these increases in Aboriginal employees. Concerted effort will be needed to improve representation across other professions as well as to support Aboriginal enrolled nurses to become registered nurses.

Most of the Aboriginal SA Health workforce worked in administrative or other roles that did not have client contact, with 64.1% of full-time equivalents filled by Aboriginal people in this area. This is an over-representation, as only 26.0% of non-Aboriginal SA Health employees work in this area. The administrative and non-client workforce had the highest representation of Aboriginal people in 2014 with 4.5% of full-time equivalents working in these roles identified as Aboriginal.



5.5: Private sector employment

5.5.1: Registered health professionals

It is difficult to accurately calculate the size of the private health workforce. One dataset which does capture private sector employees is the National Health Workforce Dataset, a comprehensive database of all registered health practitioners. As such, it also includes registered health practitioners working in the community-controlled and public sectors.

Since 2012, 14 health professions require national registration, including medical, nursing, allied health and Aboriginal health practice.¹⁹¹ Registration does not include administrative staff or others who work in the health industry but do not provide health services to clients.

In 2011, 228 of South Australia's 44,461 registered health practitioners identified as Aboriginal.¹⁹² This represented only 0.5% of registered health professionals in South Australia, compared to a national average of 0.6%. The South Australian percentage rose in 2012 to 0.6% due to an overall reduction in registered health professionals to 37,758.

For both years, the highest proportion of Aboriginal health professionals was in nursing and midwifery, with 0.6% of registered nurses and midwives identifying as Aboriginal in 2011 and 0.7% in 2012.

Within South Australia, the Country North Medicare Local had the highest proportion of Aboriginal health staff in South Australia, at 1.3% in 2012. Country South was second at 0.8% and the Northern Adelaide Medical Local a close third at 0.7%.

In 2012, South Australia ranked fifth of the eight states and territories for proportion of Aboriginal health professionals, with the Northern Territory first (1.6%), Tasmania second (1.1%) and Queensland third (0.9%).

Although the number of registered Aboriginal Health Workers in South Australia continues to be low, these low numbers are likely indicative of transition to registration as Aboriginal health practitioners were not required to register until 2012. In 2010, the Aboriginal Health Council of South Australia reported that there were 57.4 full time equivalent Aboriginal Health Workers across the community-controlled sector.¹⁹³ In 2012, there were 2 registered Aboriginal health practitioners in South Australia.¹⁹⁴





5.5.2: Distribution across sectors

Using the National Health Workforce Dataset as the sum of all health practitioners in South Australia, we estimated the number of health practitioners employed outside of the public and community sectors.

We accessed data on public sector health practitioners from SA Health and on the community sector through the AIHW's 'Aboriginal and Torres Strait Islander health services report 2011-12,' which reports on all federally-funded Aboriginal primary health care services.

The National Health Workforce dataset was assumed to represent the complete set of health practitioners in South Australia given that they must register to practice. For this estimate, it was also necessary to assume that all health practitioners work exclusively in the public, community or private sector.

This method is imperfect, particularly as some practitioners work in more than one sector. Nevertheless, it allows an estimation of the number and percentage of Aboriginal health practitioners in the private sector, as well as the relative size of each sector.

**South Australian Aboriginal Health Practitioners
Work Predominately in the Public and Community Sectors (2012)¹⁹⁵**

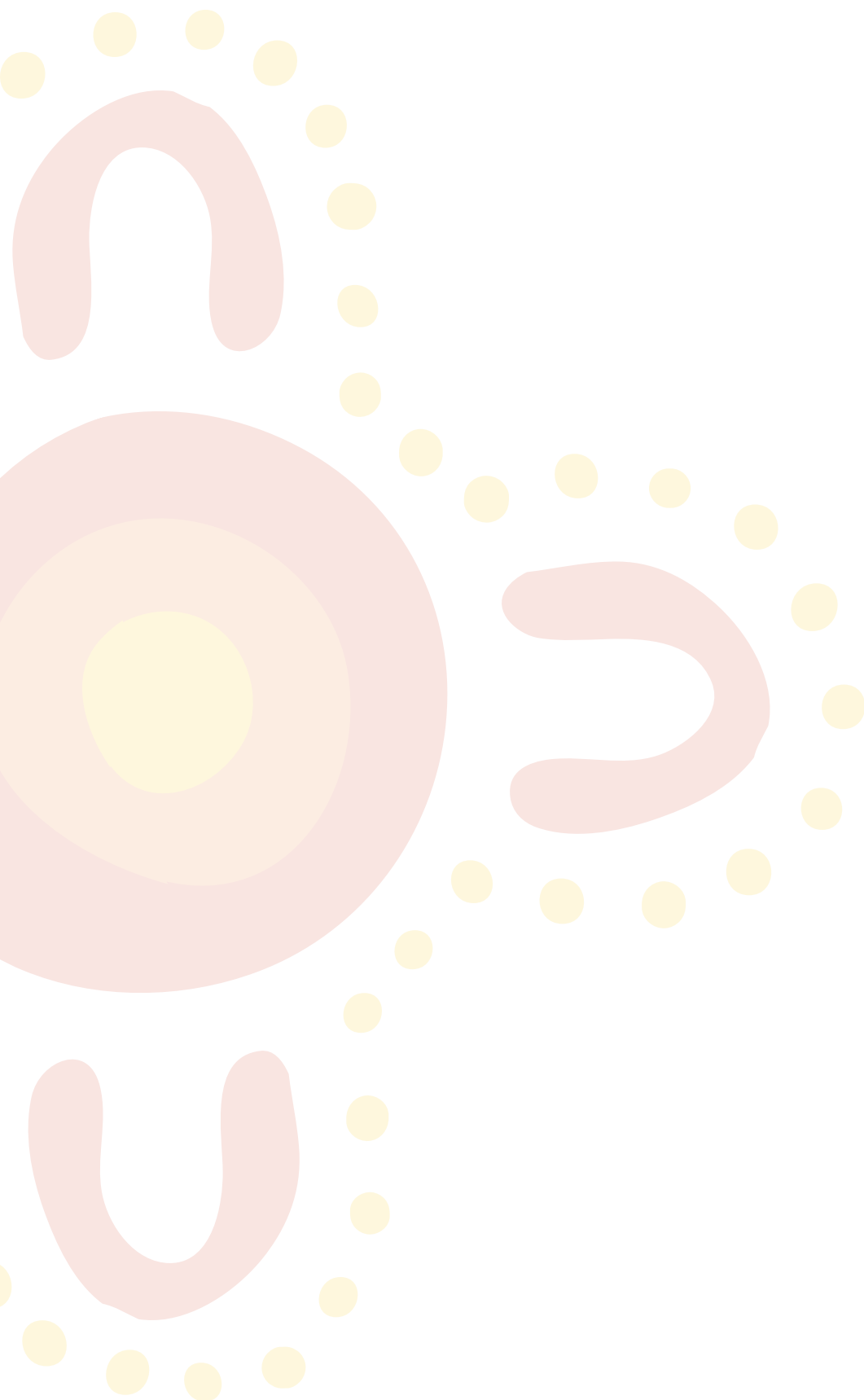
Sector	Aboriginal Practitioners	Percent of Sector Aboriginal ¹⁹⁶	Sector Share of Aboriginal Health Practitioners	Non-Aboriginal Practitioners	All Health Practitioners ¹⁹⁷	Share of Health Practitioner Employment
Public FTE ¹⁹⁸	69.7	0.7%	44.0%	9,676.9	18,706.5	66.9%
Community FTE ^{199,200}	74.9 ²⁰¹	47.2% ²⁰²	47.3%	83.7 ²⁰³	158.6	0.6%
Private FTE (estimate)	12.1 ²⁰⁴	0.1%	7.6%	9,005-9,010 ²⁰⁵	9,092.3 ²⁰⁶	32.5%
Total FTE (estimate)²⁰⁷	158.5	0.6%	100.0%	27,709.8	27,960.8	100.0%
Total Count ²⁰⁸	214	0.6%	100.0%	37,419	37,758	100.0%

Want to Know More?

Check out the HPC's *Aboriginal Population Compendium* at www.hpcs.com.au.

Many indicators in the Compendium are impacted by Aboriginal employment in the health system. The following measures may be of particular interest if you are seeking information related to workforce issues:

Access to health services [6-1, 6-2, 6-3], Access to Aboriginal health worker [6-4], Access to traditional Aboriginal healer [6-5], Antenatal visits in South Australia [6-6], Aboriginal people who identify as Aboriginal when asked by a health service [7-1], Self discharge from public hospital and discharge from hospital against medical advice [8-4], Aboriginal primary healthcare, episodes of healthcare [9-1-2], Health workforce [10-1-1], Employed nurses and midwives [10-1-2], Medical practitioners employed in medicine [10-1-3], Aboriginal employees in SA Health [10-1-4].





Appendix: People Consulted

A.1: Collaboration

We collaborated on elements of this case study with the Wardliparringga Aboriginal Research Unit (WARU) of the South Australian Health and Medical Research Institute. WARU contributed its expertise on health service standards for Aboriginal cardiovascular disease, health system barriers, and opportunities to better health outcomes for Aboriginal people with cardiovascular disease.

We also consulted closely with the Aboriginal Health Council of SA to develop our priority focus areas and on our examination of workforce issues. We consider AHCSA a key stakeholder and this consultation an important element in ensuring that the views of the Aboriginal community-controlled sector are considered.

We also consulted more widely with Aboriginal health leaders and Aboriginal leaders in other areas through two Aboriginal Leaders' Forums. The HPC was particularly interested in:

- the valuable qualitative information these stakeholders have which complements the quantitative data HPC had gathered, and
- whether the HPC's identified priority areas aligned with those of Aboriginal leaders.

A working group of Aboriginal leaders worked closely with us outside the forums. Their support was an important element to the forums being a success.

A.2: Aboriginal Leaders' Working Group

Facilitator: Klynton Wanganeen

Members:

Jacqueline Ah Kit (Women's and Children's Health Network)

Rick Callaghan (Health Performance Council)

Richard King (Department for Correctional Services)

April Lawrie-Smith (Department for Health and Ageing)

Ann Newchurch and Shane Mohor (Aboriginal Health Council)

Tamara Mackean (Flinders University)

Kim Morey and Odette Gibson (South Australian Health and Medical Research Institute)



A.3: Aboriginal Leaders' Forums

25 October 2013 and 29 May 2014

Facilitator: Klynton Wanganeen

Attendees:

Dale Agius (Department for the Premier and Cabinet)

Heather Agius (Aboriginal Elders' Group)

Jacqueline Ah Kit (Women's and Children's Health Network)

Tania Axleby-Blake (Women's and Children's Health Network)

Nancy Bates (Central Adelaide and Hills Medicare Local)

Alex Brown (South Australian Health and Medical Research Institute)

Mary Buckskin (Aboriginal Health Council of South Australia)

Christine Egan (Office of the Health and Community Services Complaints Commissioner)

Odette Gibson (South Australian Health and Medical Research Institute)

Karen Glover (Pangula Mannamurna)

Philip Graham (Department for Health and Ageing)

Lyn Jones (Child and Adolescent Mental Health Service, Women's and Children's Health Network)

Richard King (Department for Correctional Services)

April Lawrie-Smith (Department for Health and Ageing)

Cathy Leane (Women's and Children's Health Network)

Tamara Mackean (Flinders University)

Dennis McDermott (Flinders University)

Harry Miller (Port Lincoln Aboriginal Health Service)

Kim Morey (South Australian Health and Medical Research Institute)

Shouwn Oosting (Department for Further Education, Employment, Science and Technology)

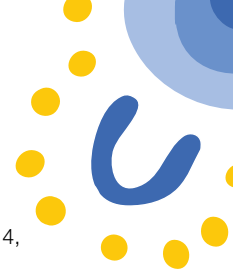
Margaret Sumner (Country South SA Medicare Local)

Nola Whyman (Southern Adelaide Local Health Network)

Jeff Hawkins (for Scott Wilson, Aboriginal Drug and Alcohol Council)

End Notes

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2. Evidenced by the 'Closing the Gap' priorities of the Council of Australian Governments.
3. BL Beagan, "Is this worth getting into a big fuss over?" Everyday racism in medical school,' *Medical Education*, vol. 37, no. 10, 2003, pp. 852-860.
4. N Pearce, S Foliaki et al, 'Genetics, race, ethnicity, and health,' *BMJ*, vol. 328, no. 7447, 2004, pp. 1070-1072.
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10. See the Council for Australian Governments' website at www.federalfinancialrelations.gov.au/content/national_partnership_agreements/indigenous.aspx for more information.
11. The direct link to the Aboriginal Health Care Plan as of 28 April 2014: <http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+reform/Strategy+for+Country+Health/Priority+areas+of+the+Country+Health+Strategy/Aboriginal+health+and+the+Country+Health+Strategy/Aboriginal+Health+Care+Plan+2010-2016>.
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 1. National average for Aboriginal representation in Aboriginal primary health-care services: 1619.6 Aboriginal FTE nationally, 1423 non-Aboriginal FTE nationally. $1619.6 / (1619.6 + 1423) = 53.2\%$ Aboriginal representation in FTE of community-controlled sector nationally.
 2. 423 known FTE in SA community-controlled sector in 2011-12 x 53.23% national average for Aboriginal employment in community-controlled sector = 225.2 Aboriginal FTE in South Australian primary health-care services.
165. Actual number of Aboriginal employees unreported; estimates used based on sources listed in endnotes 161 and 163. Calculation: 158.6 known Aboriginal primary health-care service health practitioner FTE in SA x 47.2% national average for Aboriginal FTE in Aboriginal primary healthcare service health practitioner roles (see endnote 202) = 74.9 Aboriginal health practitioner FTE in SA Aboriginal primary care services.
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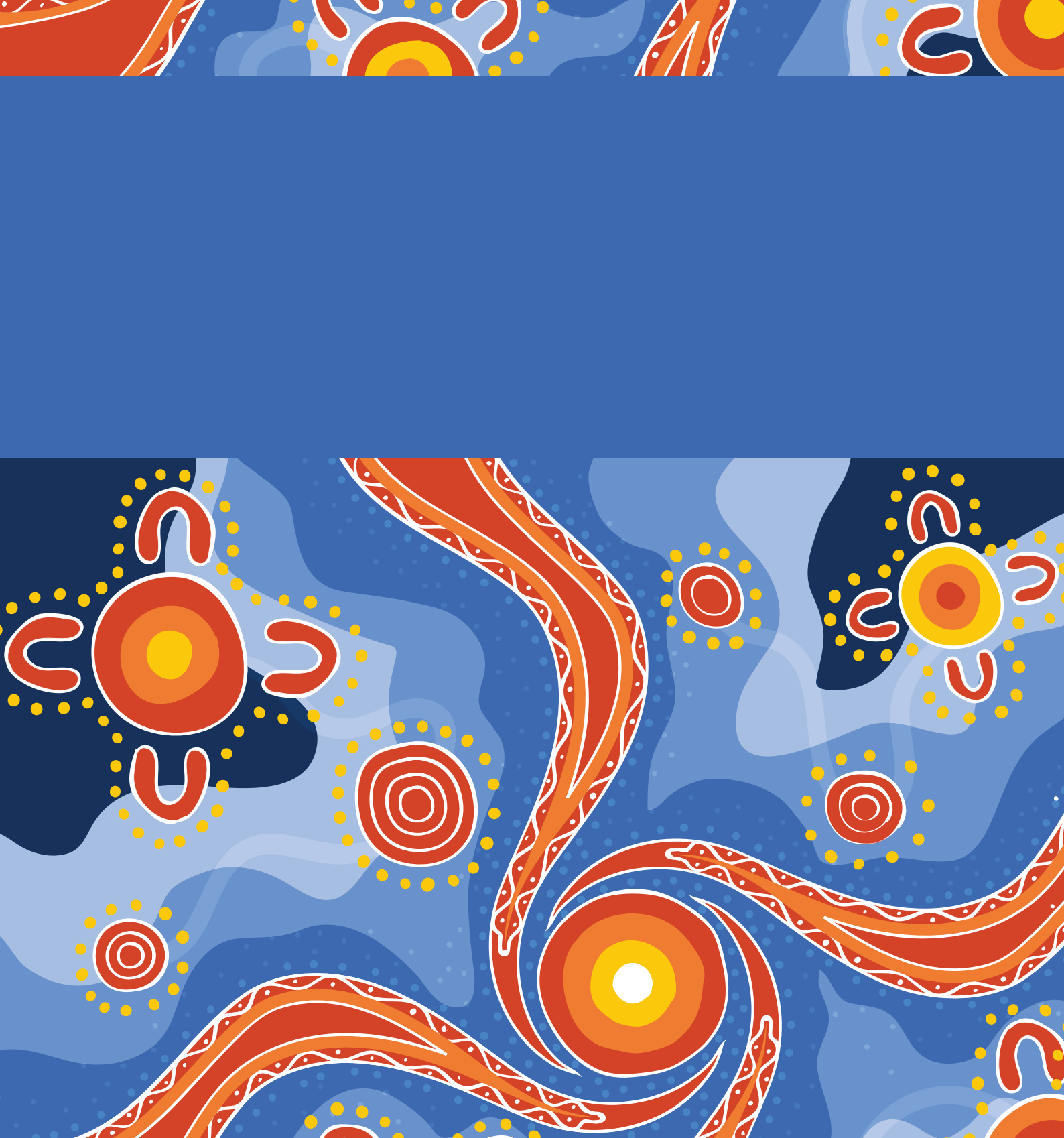


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181. Ibid.
182. Ibid.
183. Ibid; 2013 data.
184. Ibid.
185. Ibid.
186. Ranges based on those reported in the 'South Australian Public Sector Workforce Information' report 2013, which are based on Administrative Stream Officers (ASO) ranges.
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188. Of those with an Aboriginal or non-Aboriginal identifier in their records.
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191. Australian Health Practitioner Regulation Agency, *About the national scheme*, AHPRA, Melbourne, 2014, viewed 6 March 2014, <http://www.ahpra.gov.au/~link.aspx?_id=D4E5EF420D3C4EAB8B247FDB72CA6E0A&_z=z>.
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195. Includes any professional required to register with Health Workforce Australia, predominately doctors, nurses and allied health.
196. Excluding those with unknown Aboriginal status.
197. Including those with unknown Aboriginal status.
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200. Includes Aboriginal health workers, doctors, nurses, allied health professionals, medical specialists and those working in dental care.
201. Aboriginal status of employees by state not reported; estimate used based on national Aboriginal to non-Aboriginal ratio from sources listed in endnotes 161 and 163. Calculation: $158.6 \text{ known Aboriginal primary care service health practitioner FTE in SA} \times 47.2\% \text{ national average for Aboriginal FTE in Aboriginal primary care health practitioner positions (see endnotes 200 and 202)} = 74.9 \text{ Aboriginal health practitioner FTE in SA Aboriginal primary care services}$.
202. National average of health practitioners, not South Australian rate. AIHW records 1127.8 health practitioners who were Aboriginal (see endnote 200 for definition) FTE and 1262.7 non-Indigenous FTE nationally in 2012. $1127.8 / (1127.8 + 1262.7) = 47.2\% \text{ of health practitioners are Aboriginal in Aboriginal primary care services nationally}$.



203. Aboriginal status of employees by state not reported; synthetic estimate used based on national non-Aboriginal to Aboriginal ratio. Calculation: 158.6 known health practitioner FTE in Aboriginal primary health care services in SA x 52.8% national average for non-Aboriginal FTE in health practice = 83.7.
204. Private sector estimate calculated by subtracting public and community sector health practitioner FTE from FTE of all registered health practitioners.
205. Private sector non-Aboriginal FTE cannot be accurately estimated from subtracting public and community sectors from total due to significant (nearly 50%) under-recording of Aboriginal status in public sector. Two methods were used to estimate this number:
1. Assuming the proportion of non-Aboriginal employees to all health practitioners in the private sector is identical to the sector's share of health practitioners overall. Calculation method 1: Multiplying the percentage of the sector's share health practitioner employment (32.5%) with the total FTE of non-Aboriginal health practitioners (27,709.8) = 9,005.7 estimated private sector non-Aboriginal FTE.
 2. Assuming the proportion of non-Aboriginal employees to all health practitioners in the private sector is identical to that of health practitioners overall. Calculation method 2: Non-Aboriginal to total rate: 37,419 non-Aboriginal health practitioners / 37,758 all registered health practitioners = 99.1%. Multiplying the non-Aboriginal to total rate (99.1%) with total number of private sector health practitioners (9,092.3) = 9,010.7 estimated private sector non-Aboriginal FTE.
206. See endnote 204.
207. Actual FTE unreported; synthetic estimate used. Public sector ratio of count of health practitioners to FTE used to convert reported counts in *National health workforce dataset* (see endnote 208) to FTE. Calculations use public sector health practitioner count to FTE of 0.740527691 (from SA Health, Customised report, 2013).
208. *National health workforce dataset*, Health Workforce Australia and the Australian Institute of Health and Welfare, data generated 3 January 2014, annual updating, timespan covered 2010-2012, <<http://data.hwa.gov.au>>.





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